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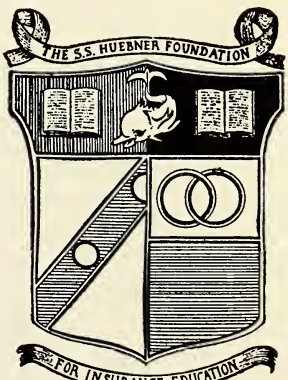
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Compulsory Temporary Disability Insurance in the United States

COMPULSORY TEMPORARY DISABILITY INSURANCE IN THE UNITED STATES

By

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To

MY FATHER AND MOTHER

THE S. S. HUEBNER FOUNDATION FOR INSURANCE EDUCATION

The S. S. Huebner Foundation for Insurance Education was created in 1940, under the sponsorship of the American Life Convention, the Life Insurance Association of America (then the Association of Life Insurance Presidents), and the Institute of Life Insurance, and operated under a deed of trust until 1955 at which time it was incorporated as a Pennsylvania nonprofit corporation. Its primary purpose is to strengthen and encourage education at the collegiate level. Its activities take three principal forms:

a) The providing of fellowships and scholarships to teachers in accredited colleges and universities of the United States and Canada, or persons who are contemplating a teaching career in such colleges and universities, in order that they may secure preparation at the graduate level for insurance teaching and research.

b) The publication of research theses and other studies which constitute a distinct contribution directly or indirectly to insurance knowledge.

c) The collection and maintenance of an insurance library and other research materials which are made available through circulating privileges to teachers in accredited colleges and universities desirous of conducting research in the insurance field.

Financial support for the Foundation is provided by contributions from more than one hundred life insurance companies and proceeds from the sale of Foundation publications.

The program of activities is under the general direction of a Board of Trustees representing the life insurance institution. Actual operation of the Foundation has been delegated to the University of Pennsylvania under an administrative plan submitted by the University and approved by the Board of Trustees. The University discharges its responsibilities through an Administrative Board consisting of six officers and faculty members of the University of Pennsylvania and three academic persons associated with other institutions. Active management of the Foundation is entrusted to an Executive Director, appointed by the University of Pennsylvania.

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Foreword

ONE of the major hazards to the personal earning capacity of the productively employed members of the population is mental and physical disability. This threat to the economic security of millions of American families may originate in a variety of ways and varies as to severity and duration. Various arrangements have been developed to cope with the economic burden of disability, two of which have been the subject of previous Huebner Foundation publications, *Total Disability Provisions in Life Insurance Contracts* by Kenneth W. Herrick and *Group Disability Insurance* by Jesse F. Pickrell. The present volume is concerned with an approach to one segment of the broad problem—temporary disability originating from nonoccupational causes.

The programs analyzed in this volume are distinctive in that they embrace the concept of compulsion. In this respect they resemble workmen's compensation, a much older and more fully developed system of indemnification for occupational disability. They also resemble workmen's compensation in that, with some exceptions, the benefits can be provided through private agencies. Like workmen's compensation and unemployment insurance, which serves as a pattern for some of the plans, the programs of nonoccupational disability dealt with in this treatise must be regarded as a form of social insurance. The study is a timely one, since many states are currently considering the establishment of similar programs.

Like most of the other Huebner Foundation publications, this volume stems from a doctoral dissertation prepared under the auspices of the Foundation's academic program. It is the eleventh volume in the "Studies" series and the eighteenth book to be published by the Foundation.

The author, Dr. Grant M. Osborn, is a native of Utah, having been born in Salt Lake City. After military service in World War

II, he attended Brigham Young University, graduating with a B.S. degree in 1948. His first two years of graduate work were carried out at Stanford University where he received the M.B.A. degree in 1950. He was in residence at the University of Pennsylvania from 1950 through 1954 under a Huebner Foundation fellowship grant and was awarded the Ph.D. degree in February, 1956. Upon completion of the graduate program at the University of Pennsylvania, Dr. Osborn accepted a teaching position at the University of Omaha. Since the fall of 1957, he has been at Arizona State University where he holds the rank of Associate Professor of Insurance.

The nature of the purposes for which the Foundation was created preclude it from taking an editorial position on controversial insurance theories or practices. It does not, therefore, detract in any wise from the quality of this volume to state that the findings of fact and conclusions derived therefrom are those of the author and not of the Foundation.

DAN M. MCGILL
Executive Director

Philadelphia
July, 1958

Preface

COMPULSORY temporary disability insurance, providing benefits for temporary nonoccupational disability, is the most recent of major developments in American social insurance. The first legislation was enacted in 1942, yet by the end of 1950 approximately ten million workers were covered by the various programs. Interest in this field has stimulated considerable discussion. Partisan groups have not hesitated to present their respective viewpoints, but no impartial, comprehensive studies have been published. Very few studies of any kind have been undertaken in this field during the past few years. The purpose of this study is to determine, on the basis of experience here and in Europe, the feasibility of compulsory temporary disability insurance in the United States. The method used is an analysis of the problems that have arisen in the temporary disability insurance programs in this country; and the problems have been classified as they pertain to coverage, benefits, finance, and administration. It is hoped that this study will be of interest and use to those active in the field, and that perhaps it may serve as a guide to study commissions appointed to consider temporary disability legislation.

This study is divided into four sections: (1) the first two chapters furnish background, (2) chapters three and four provide a history, (3) chapters five and six briefly describe the statutes, and (4) the last four chapters present the problem analysis. Most data are as of January 1, 1955.

Analysis of the railroad program is limited. The railroad temporary disability program is unique in that it is part of special legislation passed for that industry alone. Its administration is more closely integrated with unemployment compensation (so much so that no person works exclusively with the disability program) than any other program has been. Other features of the program are such that its experience would not be sufficiently

applicable to other programs to justify more extensive analysis here.

Terminology in this field is far from standardized. Cash sickness benefits, disability compensation, sickness compensation, unemployment compensation disability benefits, nonoccupational disability benefits, and other terms, have been used to describe these programs. However, the term "temporary disability insurance" is descriptive and is widely used.

The paucity of written material available necessitated extensive use of the personal interview. Since many of the topics are controversial, few of the persons interviewed wished to be quoted. Most insurance executives were very co-operative in providing desired information, but requested that it be kept confidential for competitive reasons. Consequently, some substantiating data are missing and some sources are not specifically credited.

This study would not have been possible without considerable help from men in the state and federal governments, leaders of labor and industry, independent consultants and educators. It is a pleasure to acknowledge the assistance at the state level of William F. Dittig, Superintendent of Disability Insurance Service for New Jersey; H. M. Wilson, Director of Disability Insurance and Hospital Benefits and George S. Roche, Chief of Research and Statistics for California; W. E. Connell, Director of Temporary Disability Insurance for Rhode Island; J. T. Lillis, Senior Publicity Agent, New York Workmen's Compensation Board; W. B. Kole, Principal Actuary, New York State Insurance Fund; and M. J. Schwartz, Associate Actuary, New York State Insurance Department. Federal employees especially helpful were H. L. Carter, Director of Unemployment and Sickness Service, Railroad Retirement Board; Margaret M. Dahm of the Bureau of Employment Security; William Gafafer of the Division of Occupational Health; and Barkev Sanders of the Federal Security Agency.

It is not possible to acknowledge the help of everyone in the insurance industry who contributed to the study. Those who were of particular help were A. C. Olshen, Vice President and Actuary, West Coast Life Insurance Company; H. Harold Leavey, Vice

President and General Counsel, California-Western States Life Insurance Company; Reinhard A. Hohaus, Vice President and Actuary, and James Fitzpatrick, Superintendent of the Disability Benefits Section, Metropolitan Life Insurance Company; J. Henry Smith, Vice President and M. D. Miller, Associate Actuary, Equitable Life Assurance Society; Wendell Milliman, formerly Vice President, New York Life Insurance Company and now consulting actuary, Milliman and Robertson; Stanley Gingery, Associate Actuary and Frank Walsh, Director of Group Insurance Relations, Prudential Insurance Company; Armond Sommer, Executive Vice President, Continental Casualty Company; E. H. Marshall, Assistant Secretary, Insurance Company of North America; Edward A. Green, Vice President, John Hancock Mutual Life Insurance Company; John Garman, Manager of the Group Department, Connecticut General Life Insurance Company; and James K. Honey, Assistant Counsel, Life Insurance Association of America.

Charles Scully, Counsel for the California State Federation of Labor, Wilbur Daniels, Assistant General Counsel, International Ladies' Garment Workers' Union, and T. L. Parsonnett, Counsel for the New Jersey State Federation of Labor were helpful in presenting the viewpoints of labor. Others who contributed to the study were Marvin Bloom, Research Council for Economic Security; George Cooley, American Medical Association; Robert Tilove, Martin E. Segal and Company; Nathan Sinai, University of Michigan; Herman Gray, New York University; John Bickley, The Ohio State University; Richard Lester, Princeton University; S. H. Patterson, University of Pennsylvania; and Leland B. Groezinger, San Francisco.

The author was the recipient of a Huebner Foundation Fellowship while the study was in progress and is deeply indebted to the Foundation for the financial assistance provided. The personal help of the late Dr. David McCahan, former Executive Director, and Dr. Dan M. McGill, present Executive Director of the Foundation is also gratefully acknowledged.

The late Dr. C. Arthur Kulp, under whose direction the study was conducted, helped far more than should be expected of a

faculty adviser. The hours of consultation, the painstaking criticism of written work, and the encouragement given are sincerely appreciated.

Much of the editorial work on the manuscript was done by Mrs. Alice Eshbach. Miss Mildred A. Brill, Administrative Assistant in the Foundation, proofread the manuscript and handled the details of publication.

GRANT M. OSBORN

Tempe, Arizona
July, 1958

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PART · I

Introduction

CHAPTER • 1

The Hazard of Temporary Disability

THE major economic hazard confronting a gainfully employed individual is the inability to work because of sickness or accident. It has been estimated that during an average day more than two million persons are kept from their jobs by temporary disability, and that the nationwide cost in lost wages, medical-care bills, and related expenses is in excess of $18 billion a year.[1] Except during periods of excessive unemployment, disability has been given as the primary reason for seeking charity and relief. The consequences of this hazard are partially mitigated by workmen's compensation benefits. But off-the-job sickness or accident, really the greater hazard, remains a formidable problem to most workers.

This chapter will discuss the nature, extent, cost, and causes of temporary disability, as well as the relation of disability to factors such as age, sex, and income. Most data in this field do not distinguish temporary from permanent disability. These general data have been used, with limitations, however, where more pertinent data have not been available.

NATURE OF THE DISABILITY HAZARD

In order to study the hazard of disability, and particularly to devise measures to combat its effects, we must first understand what it is. A definition of disability will vary according to the purposes for which the definition is to be used. In considering

[1] Research Council for Economic Security, *Disability* (1947), pp. 4, 6.

the economic consequences of disability the definition should be in economic terms. Probably the simple definition "inability to perform regular or customary work" is most suitable.[2] The qualifying adjective "temporary" usually refers to disability lasting twenty-six weeks or less. The initial twenty-six weeks of prolonged disability are also classified as temporary.

Fewer problems arise in defining disability resulting from accidents than from sickness. Disability resulting from an accident is definite as to time and cause, and external symptoms such as fractured bones or lacerations are usually self-evident. This is in contrast to the general debilitation usually accompanying the more common illnesses. Disability due to sickness is more important than,[3] and more subjective than, disability resulting from accident. This subjectivity presents a problem of definition. Some individuals are incapacitated by relatively minor illnesses, others continue at gainful work though they may reasonably be regarded as incapable of working. The personal physician is often more prone than the company doctor to certify the patient as disabled. Disability is often affected by economic factors. When the pay is unsatisfactory, or there is no job to return to, the patient's will to recover is often severely impaired. During periods of high employment there are many marginal workers in the market who at other times consider themselves unemployable due to disability. These problems in defining disability make it difficult to design and administer an insurance system against the hazard.

It is often said that adequate insurance statistics are available only subsequent to the insuring of the hazard. The hazard of disability is not uniformly insured in this country. Consequently, there is a dearth of the data desired for a temporary disability insurance system. Some information is available on disabilities which result from injuries and diseases due to employment, but these are a small fraction of the total. The experience of private

[2] See also "Definition of Disability," Chapter 8.

[3] Surveys show that contrary to popular impression, sickness rather than accident is the major hazard. This mistaken view probably stems from the dramatic and definite nature of accidents. Some estimate that less than 10 per cent of all days lost through disability by the working population is due to accidents, industrial or otherwise.

insurance companies and of social insurance schemes, here and abroad, provide further information. But most disability statistics are based on two comprehensive studies made in this country some years ago.[4] These data are frequently modified by those interested, to account for population, income, and other relevant changes.

The temporary disability insurance program in California has accumulated extensive data and has subjected them to analysis pertinent to this study. These are among the first data available from a compulsory temporary disability insurance program in this country indicating frequency and duration of disability, but care must be exercised in their application to other programs. Those administering a program with different provisions, or a dissimilar work force would find it necessary to modify these data.

The experience of commercial insurers in this country and of the compulsory programs in Europe indicates that even if the data gathered prior to the inauguration of an insurance scheme for disability are reliable, they may not be wholly relevant, since the risk seems to develop its essential characteristics subsequent to insuring. Changes are believed to be of threefold origin. First, when accurate records are kept, many illnesses are reported which would otherwise be overlooked. Disability surveys often rely upon the memory of the respondent, which may be inaccurate. Second, when workers know that their income will not be terminated by illness, they will often stay home and draw benefits, whereas, without sick-pay benefits they would have felt compelled to stay on the job. Third, malingering, though overstressed by many, is a factor to be considered in the insuring of disability.

EXTENT OF TEMPORARY DISABILITY

No comprehensive studies have been made to determine the extent of nonoccupational temporary disability among the general working population. Data from the California program are utilized in this section.

[4] The first is the 1928–31 study conducted by the Committee on the Cost of Medical Care; the second is the National Health Survey of 1935–36.

Frequency of Temporary Disability

The frequency rate—that is, the number of compensable spells of disability begun during the year for each 1,000 qualified employees—for the California program[5] during 1953 was 100.3 spells of temporary nonoccupational disability.[6]

The frequency rate increased each year from 1950 through 1953; the reports for 1955, however, indicated a leveling off at a figure slightly below that for 1953.[7]

The over-all frequency rate rose as the age of the eligible group increased (see Table 1). Eligible persons under twenty years of age showed a very low frequency rate, while this rate rose sharply after age sixty. Substantial differences in frequency rates are also noted between the sexes. These differences and other factors are discussed later.

TABLE 1

Estimated Frequency Rates by Age: Total and by Sex, California Program, 1953

Age Group	*Total*	*Men*	*Women*
All age groups	100.3	84.0	135.3
Less than 20	30.0	25.7	35.6
20–29	71.7	52.4	107.1
30–39	87.9	64.0	142.3
40–49	109.0	85.7	160.3
50–59	133.1	123.5	155.5
60–69	186.5	184.3	193.7
70 and over	215.7	222.5	185.4

Source: California Department of Employment, *Report 1120 #3b*, July 5, 1956.

Duration of Temporary Disability

Information on the duration, as well as the frequency, of disabilities is necessary to determine the cost of a temporary dis-

[5] These data include the limited benefits granted for pregnancy. See page 65.

[6] California Department of Employment, *Report 1120 #3b*, July 5, 1956.

[7] Report of the Actuaries for Calendar Year 1955, *An Analysis of Developments Affecting the Actuarial Position of the California Unemployment Compensation Disability Fund*, June 27, 1956, p. 21.

ability insurance program. Since a California worker must be sick at least eight days before he can receive benefits, the duration figures from this program are for spells of disability lasting eight days or more.

TABLE 2

DURATION OF DISABILITIES, CALIFORNIA PROGRAM, 1955

Percentage of Spells Lasting Specified Number of Weeks										
Total	Over 1 to 2	Over 2 to 3	Over 3 to 5	Over 5 to 7	Over 7 to 9	Over 9 to 11	Over 11 to 15	Over 15 to 19	Over 19 to 23	Over 23 to 27
100	17.9	13.4	18.0	12.2	8.3	5.7	7.4	4.0	2.7	10.4

Source: California Department of Employment, *Report 1031* #7, Table 7, May 3, 1956.

Among workers in California, disabilities of eight or more days duration which began in 1955 lasted, on the average, approximately 7.4 weeks. The above table shows that almost half of the disabilities lasted no more than five weeks, two thirds lasted no more than nine weeks.

The duration of disabilities was affected by age and sex, lasting considerably longer among older workers than among younger workers, and generally lasting longer for women than for men. These factors will be discussed at greater length below.

COST OF TEMPORARY DISABILITY

The financial impact from temporary disability is often a catastrophe to the disabled worker. In addition to the loss of income, he often incurs substantial bills for medical care. While this study concerns itself primarily with loss of income, those additional expenses make it even more imperative to provide income to the worker during disability.

Most cost data in the disability field are general and do not distinguish costs attributable to temporary disability. This is par-

ticularly true for medical-care costs. Consequently, only rough estimates of costs due to temporary disability can be made from the totals.

Cost of Medical Care

The total expenditures for medical care in this country are large. It is estimated that the total outlay for all private, personal medical care in 1953 was approximately $10.2 billion. The medical-care dollar is divided as follows: physicians, 37 per cent; hospitals, 20 per cent; dentists, 16 per cent; prescriptions and other medicines, 15 per cent; other medical goods and services, 13 per cent.[8] For the past two decades medical-care expenditures have varied from 4.0 to 4.5 per cent of total consumer expenditures.[9]

One study estimated that approximately 75 per cent of total expenditures for medical care were made for temporary disability.[10] On the basis of this estimate, approximately $7.6 of the $10.2 billion expended for medical care in 1953 was paid as a consequence of temporary disability. Medical-care costs today are higher, because of price increases.

The average yearly expenditures by individuals for medical care are not large. However, the burden of these expenditures is unevenly distributed. A small percentage of the population suffers severe economic losses as the result of disability every year, and studies show that the severe losses fall on a different group each year. A recent study found that among all families, 15.5 per cent experienced medical-care costs in excess of $395; 10.6 per cent in excess of $495; and 2.0 per cent in excess of $995. Applied to the entire population this means that in 1953 approximately one million families in the United States experienced costs for personal health services in excess of $995.[11] The Committee on the Costs of Medical Care found that 58 per cent of the families

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[8] Odin W. Anderson, *Family Medical Costs and Voluntary Health Insurance: A Nationwide Survey* (New York: McGraw-Hill Book Co., Inc., 1956), p. xii.

[9] American Medical Association, Bureau of Medical Economic Research, *Miscellaneous Publication M–69*, p. 2.

[10] Research Council for Economic Security, *op. cit.*, p. 6.

[11] Anderson, *op. cit.*, p. 28.

covered by its survey paid 18 per cent of the total outlay, that 32 per cent paid 41 per cent of the total, while 41 per cent of the total cost of medical service was paid by an unfortunate 10 per cent of the families. These and other studies show that approximately 15 per cent of the people pay half of the total medical-care bill every year. Such extreme variations make it difficult, if not impossible, for the individual to budget the consequences of disability.

Loss of Income

Estimates of the average annual wage and income loss due to temporary disability vary widely. But all agree that the total is great. The Advisory Council on Social Security to the Senate Committee on Finance estimated in 1949 that wages amounting to $5 to $6 billion are lost every year because of temporary disability alone.[12] An estimate by the U.S. Chamber of Commerce and the Research Council for Economic Security, adjusted for price level changes, would place the wage loss due to the same hazard at approximately $4.5 billion.[13]

The burden of income losses resulting from temporary disability closely parallels the incidence of medical-care costs. A study by the Illinois State Health Insurance Commission showed that more than 50 per cent of the workers lost less than 10 per cent of their annual wages, and that about 10 per cent of the workers lost 40 per cent or more of their annual wages.[14]

CAUSES OF TEMPORARY DISABILITY

The California program has provided considerable information on the causes of temporary nonoccupational disability. These data confirm reports from other studies that have pointed out the

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[12] United States Senate, *Recommendations for Social Security Legislation*, 80th Cong., 2nd Sess., Document No. 208, p. 181.

Recent estimates by the Social Security Board put this loss at approximately $6 billion.

[13] Research Council for Economic Security, *op. cit.*, p. 6.

[14] H. A. Millis, *Sickness and Insurance* (Chicago: University of Chicago Press, 1937), p. 5.

relatively minor part accidents play in disability of temporary nonoccupational origin.

Disease

Disease groups that included the largest number of beneficiaries were diseases of the digestive system, diseases of the circulatory system, neoplasms, diseases of the genito-urinary system, diseases of the respiratory system, and diseases of the bones and organs of movement, in that order, as shown in Table 3.

TABLE 3

CAUSES OF DISABILITY, CALIFORNIA PROGRAM, 1953

Sickness Groups	*Percentage of Total*
Diseases of the digestive system	15.1
Diseases of the circulatory system	14.6
Neoplasms	8.6
Diseases of the genito-urinary system	8.5
Diseases of the respiratory system	7.8
Diseases of the bones and organs of movement	6.7
Mental, psychoneurotic, personality disorders	5.6
Diseases of the nervous system and sense organs	5.2
Infective and parasitic diseases	4.3
Allergic, endocrine system, metabolic and nutritional diseases	3.4
Diseases of the skin and cellular tissue	2.1
Diseases of the blood and blood-forming organs	1.0
Deliveries and complications of pregnancy	0.4
Congenital malformations	0.4
Accidents, poisonings, and violence	13.5
Others	2.8

Source: Adapted from *Report 1010 #41* compiled by the California Department of Employment, July 7, 1953.

Accidents

Accidents accounted for 13.5 per cent of the total disabilities in the California study. Fractures accounted for approximately 42 per cent, and sprains and strains approximately 23 per cent of all accidents.

RELATION OF DISABILITY TO OTHER FACTORS

Disability is a multifaceted problem. Among the many factors associated with it are age, income, and employment, as well as

other, minor factors. The relationship of these factors to disability will now be discussed in general terms.

Disability and Age

Frequency of disability varies considerably with age. As usual, frequency rates in the California study increased with age, ranging from a low of 30 per 1,000 in the ages under 20 years, to a high of 215.7 per 1,000 in the ages over 70 years. The extent to which frequency rates tended to rise with age is shown in Table 1, page 6.

Age has an important bearing on the duration of disabilities. Table 4 shows that each successive age group has an average duration of recorded disabilities for both sexes which is higher than the duration for the previous age group. In the age group 20–24 years, the average duration was less than eight weeks. In the age group 65 years and over, however, the average duration was 15.3 weeks, or almost twice the average duration of the younger workers.

TABLE 4

AVERAGE DURATION OF DISABILITIES BY AGE OF BENEFICIARY, CALIFORNIA PROGRAM, 1949–50

(In Weeks)

Age Group	*State Plan (Nonextended Liability)*		*Voluntary Plans*	
	Men	*Women*	*Men*	*Women*
20–24 years	6.9	8.0	4.2	5.1
25–29	7.1	8.6	4.1	6.0
30–34	7.1	8.8	4.3	6.4
35–39	7.8	9.4	4.7	6.8
40–44	8.3	10.1	5.0	7.2
45–49	8.9	10.4	5.8	7.3
50–54	10.0	10.8	6.8	7.8
55–59	11.1	11.2	7.7	7.9
60–64	12.0	12.8	8.8	8.9
65 and over	15.3	15.3	11.4	11.7

Source: Letter from George S. Roche, Chief Research and Statistics, California Department of Employment, April 2, 1957.

Disability and Sex

Although mortality experience of women is better than that of men, the evidence is clear that the reverse is true for morbidity. Women experience more disabilities than men.

In the California study, frequency rates for women were higher than those for men—135.3 spells per 1,000 as compared with 84 per 1,000. The same study further showed that disabilities generally lasted longer for women than for men. The median duration per spell was 7.8 weeks for women and 7.4 weeks for men.

An interesting development of this study was that although in the younger age groups frequency rates for women were considerably higher than those for men, in the oldest age group the opposite was true. The highest frequency rate for women occurred in the ages 60–69; for men the highest rate occurred in the ages 70 and over. At least one commercial insurance carrier has reported similar experience.

Disability and Income

Disability not only increases the expenses of those families afflicted, but it falls with greatest weight upon those who are less able to pay. Studies of the National Health Survey show greater than average incidence of disability among those on relief and among those having the lowest incomes. The Survey was made in 1935–36, and at that time gainfully occupied persons aged 15–64, in families on relief, had 13.8 average annual days of disability per worker; those in nonrelief families with annual incomes under $1,000 had 9.1 days, while workers in families with incomes of $1,500 and over, had 5.7 days, or less.[15] There appeared to be little or no relationship between amount of income and days of illness in families with incomes of $1,500 or more. Many other studies have shown similar results. While average incomes have changed markedly since this study was made, it is probable that the same relationships exist for comparable income levels today.

[15] I. S. Falk, Barkev S. Sanders, and David Federman, *Disability among Gainfully Occupied Persons* (Social Security Board, 1945), p. 9.

Relief and low-income families not only experience more frequent illnesses during a year than their more fortunate neighbors, but their illnesses are, on the average, of longer duration. The above survey indicated that illnesses disabling for one week or longer in a twelve-month period, occurred among families on relief at a rate 57 per cent higher than among families with annual incomes of $3,000 and over. Considering illnesses broadly classified by cause, it was found that the highest frequency rates for both acute and chronic illness[16] were those of the population on relief: for acute illness, the excess for the relief group was 47 per cent; for chronic illness, 87 per cent, compared with the rates for the highest income class.

It is difficult to determine to what extent such increased disability is the cause or the result of low income. Surely the poorer living conditions, low-quality food, and inadequate medical attention resulting from low income contribute to disability. Another contributing reason for the higher illness rates among the poor may be that they often have jobs requiring physical labor which a half-sick person cannot perform. It is also true that family income drops during sickness or disability of the income earner. Thus, disability may be a cause as well as a consequence of low income, and the disability rate may reflect this relationship.

Disability and Employment

One of the important findings of the National Health Survey was that unemployed workers are twice as likely to be disabled by illness as are employed workers.[17] Among male and female workers, age 15–64 years, employed workers had a disability rate of 19.5 per thousand, while unemployed workers had a rate of 39.5.[18]

The excess of illness among workers without jobs was not con-

[16] In this study, the symptoms of disease which were less than three months in duration were classified as "acute," those with symptoms of three months or longer were designated "chronic."

[17] Unemployables were not included with the unemployed workers in this study. The rate would have been greatly increased if this had been done.

[18] The National Health Survey, *Preliminary Reports, Bulletin No. 7, op. cit.*, p. 1.

fined to particular groups. Such excess was found among high as well as low-income groups, and among the professions as well as among unskilled laborers. Excessive illness was found among unemployed workers whether young or old, and among unemployed women as well as among unemployed men. The highest disability rates were found among workers in the older-age groups, in the low-income classes, and among unskilled laborers.

The experience of the temporary disability insurance programs has substantiated the findings of the National Health Survey. The California program has had markedly higher frequency rates among beneficiaries who are unemployed at the inception of disability. The study of the experience in 1953 showed that the average frequency rate for the Extended Liability Account (from which benefits are paid to those who were unemployed at the inception of disability) of the State Fund was 170.0 per thousand, while the rate for the Nonextended Liability Account (from which benefits are paid to those who are employed at the inception of disability) was 78.2.[19]

Such data are often interpreted to mean that unemployment is a primary cause of disability. This may well be true since unemployment is accompanied by lower incomes, which, accompanied by poorer medical care and a generally lower standard of living is not conducive to good health. And even when unemployment does not result in privation, the change in pace, emotional and physical, induced by such a state, as well as fears for the future, may have serious physiological consequences. However, the converse is also true, namely, that disability is a cause of unemployment. That illness is an important reason for loss of job is commonly recognized. Each year many workers are laid off as a result of accident and disease.

Other Factors

Many factors other than those discussed above are associated to a greater or lesser extent with disability; e.g., occupation, economic conditions, marital status, and race.

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[19] California Department of Employment, *Report 1120 #3b*, July 5, 1956.

The rate of disability generally tends to rise and fall inversely with a nation's economic conditions. Much of this association is allied with the factors of income and employment. When a nation's economy is in high gear, individual incomes are high, which promote conditions favorable to good health. A high national income is usually associated with low unemployment, too, with a lower disability rate resulting. The reverse is usually true during periods of depression.

It has been found that married women usually have poorer morbidity experience than their unmarried counterparts even excluding disability arising out of pregnancy. This difference may be attributable to the higher average age of the married groups, and may really be more a function of age than of marital status as such. It is also conceivable that with heavy domestic responsibility there is a greatly increased temptation to malinger or a tendency to somaticize domestic problems. Certain races in this country experience higher disability rates than the nationwide average. It is generally considered that this high rate is due primarily to economic and environmental conditions rather than differences in race *per se.*

SUMMARY

The disability hazard is an intangible. It is subjective. A disability that merely inconveniences one individual may incapacitate another. An individual's attitude toward the same disability may differ depending upon economic conditions, incentives, and other factors; so that at one time he may work despite the disability, while at other times he may remain at home. This subjectivity creates major problems in defining the hazard and in computing meaningful statistics.

It has been said that disability rates "do not add up," and never will until we have standard bases. This is especially true for temporary disability data, which are largely inferences from more general studies. Furthermore, it is believed by many that adequate statistics will not be available until the hazard is widely

insured on a uniform basis. It is quite true that the risk is largely an unknown until it is insured.

However, studies indicate that the risk is measurable. They further indicate that the consequences of the hazard fall unevenly upon the victims, and the most burdensome costs often fall most heavily upon those least able to afford them. This uneven distribution of the costs makes it difficult, and in many cases impossible, to budget the risk. Such factors highlight the feasibility of, and the need for, insuring this hazard.

The problem of temporary disability is a major one. Industry and society as a whole are adversely affected by the consequences through lost production, increased costs, and the general lowering of morale. Most seriously affected, however, are the disabled individuals and their dependents. They are the ones who suffer the reduced incomes, the lowered standards of living, and often poverty, as a consequence of disability. Temporary disability is the most persistent, serious, and uncertain hazard confronting the mass of our working population.

CHAPTER • 2

Voluntary Temporary Disability and Medical-Care Insurance

An awareness of the temporary disability problem has led to voluntary efforts toward mitigating its consequences. As was brought out in Chapter I, medical-care costs incurred, as well as income lost, during periods of temporary disability present financial problems to the disabled. Consequently, insurance coverages have been devised to meet both hazards. While this study is primarily concerned with income-replacement insurance, medical-care coverages have been widely sold and are discussed as part of the over-all problem.

Great progress has been made during the past decade in providing millions of people with voluntary insurance against the hazard of temporary disability. Yet many have very inadequate protection, and still others remain without any protection whatsoever against this hazard. The limitations of voluntary effort have led many to believe that legislation is necessary to compel the adoption of more adequate measures.

MEDICAL-CARE AND HOSPITALIZATION INSURANCE

Among the major economic losses attributable to temporary disability are medical-care and hospitalization costs. A portion of these costs is met today by voluntary prepaid plans—both nonprofit and commercial. Some of the costs are met by government, others by charitable organizations, and many are paid out of current earnings by those afflicted.

It is estimated that over 107 million individuals are now protected against medical-care costs by some form of prepaid insurance.[1] The total includes many dependents and others who would never be included in a temporary disability insurance program, but the primary basis for much of the coverage is the employment status of the subscriber. This is true since the major portion of such coverage is provided through group insurance—either Blue Cross and Blue Shield or commercial insurance. It is difficult to estimate the number of workers insured by these plans, but the total probably exceeds 46 million.[2]

Nonprofit Plans

There has been a remarkable growth in the development and use of nonprofit plans to meet hospitalization and medical-care costs in the past decade. The plans meet the need for some scheme to enable individuals to budget the cost of potential hospitalization or medical care and consequently have had widespread acceptance. The plans were sponsored and developed primarily by hospitals and the medical profession, and have remained producers' rather than consumers' organizations. A large majority of these organizations are either Blue Cross or Blue Shield plans.

Blue Cross. The growth in membership of the Blue Cross plans has been little short of spectacular. Most progress has taken place since World War II. There were approximately 50.7 million subscribers in 1955.[3]

Some of the factors that have contributed to this growth are: intensive promotional efforts, favorable economic conditions, increased awareness on the part of the public of prepayment plans, consideration of medical-care and hospital benefits in labor-management negotiations, and pressures to include such benefits in federal legislation. The rate of growth of these plans has in recent years, naturally, dwindled. The most likely prospects are already enrolled, increased costs have resulted in higher premiums, and

1 Estimates based on data from the Health Insurance Council, *Annual Survey, Accident and Health Coverage in the United States*, October, 1956, p. 13.

2 *Ibid.*, p. 20.

3 *Ibid.*, p. 13.

competition from commercial insurance companies has increased.

Enrollment is achieved primarily through groups of employed persons at their place of employment. Usually a certain minimum percentage of the group must enroll before the group is accepted. The trend has been to accept smaller and smaller groups. Many plans now permit individual enrollment during specified periods. It has long been the practice to permit those who left the group where they were originally enrolled to continue their coverage as individual members. Experience with members enrolled on an individual basis has been poor in many plans.

Health examinations are usually not required, even when members are enrolled individually. Most plans do not have age limits on group membership, but usually do have age limits on individual enrollments. Children enrolled as family dependents lose that status upon attaining 18 or 19 years of age.

Premiums are usually paid in monthly installments. Individual members are encouraged to pay quarterly, semiannually, or annually. Rating classifications are usually restricted to two, or at the most, three groups. Sometimes single subscribers are charged one rate and family units another. Or the rate groups are for single subscribers, married couples, and families.

Benefits are usually provided in service; some, however, provide cash. The scope of benefits provided is broad, although complete protection is not the rule. The usual benefits are: semiprivate room for thirty to ninety days,[4] use of operating rooms, anesthetics administered by staff personnel, drugs, dressings, laboratory services, and some X-ray services. Maternity care is often included after expiration of a ten-month waiting period. Benefits are provided for most disabilities. There are, however, sometimes exceptions, or limited benefits, for disabilities arising from occupational injuries, venereal diseases, self-inflicted injuries, and mental or nervous disorders. All plans pay specified amounts toward the

[4] Some plans now offer somewhat greater maximum benefits, subject to a small deductible. A more recent development is the co-ordination of "major-medical" coverage with the basic Blue Cross contract. This new coverage contains a 75 per cent coinsurance requirement, a deductible of $200 and a top limit of $5,000 per contract year. From *Group Briefs*, a mimeographed release of the Health and Accident Underwriters Conference, June 30, 1955.

hospital bills of members who are confined in nonmember hospitals.

Blue Shield. The enrollment progress of Blue Shield plans has also been rapid. The 4.5 million original subscribers in 1945 had increased to 39.2 million by the end of 1955.[5] Much that has been said above about Blue Cross plans, such as enrollment methods, physical examinations, and premium payments, is also pertinent to Blue Shield.

Generally the plans offer a choice between two contracts. One provides surgical service (including obstetrical care) and physician's care in hospitals only; the other provides physician's care in the home and office in addition to the above. Benefits are provided on a service basis (doctors are paid in full directly by the insurer) as well as on a cash indemnity basis (the insured is billed by the doctor and reimbursed by the insurer according to contract provisions). Usually only those in the lower-income groups are eligible for service benefits. Subscribers with incomes above the specified minima are granted dollar allowances, by schedule. Doctors charge the latter their usual fees—patients paying the difference between the scheduled allowance and the actual fee charged. "The effect of cash indemnity is to protect the physician's income rather than the patients' financial status."[6]

Commercial Plans

Hospital Expense Benefits. The development of commercial hospitalization insurance followed that of the nonprofit plans. Pioneering efforts were made in the 1930's, but here again the most significant growth has been exhibited in the past decade. At the end of 1955 there were approximately 65.7 million people, including dependents, with hospitalization insurance provided by commercial insurers. The majority of these, some 60 per cent, were covered under group plans.[7]

Group Hospitalization. Group hospitalization coverage is

[5] Domenico Gagliardo, *American Social Insurance* (New York: Harper & Bros., 1955), p. 563; The Health Insurance Council, *op. cit.*, p. 13.

[6] Gagliardo, *op. cit.*, p. 566.

[7] The Health Insurance Council, *op. cit.*, p. 13.

provided largely by life insurance companies, although the casualty companies have made considerable progress recently. Hospitalization insurance can be obtained separately, but is usually provided in conjunction with other disability coverages. The minimum size of the group for which these coverages are available has been decreasing constantly, so that it is possible today to cover groups of only a few employees. The privilege of permitting the individual to continue the insurance after he leaves the group is often extended.

As is true for other group disability insurances, hospitalization policies are relatively free from exclusions and restrictions. Hospitalization covered by workmen's compensation is one of the few exclusions. It is required that a certain minimum number of the group accept the insurance in order to combat adverse selection. In addition, insurance is usually restricted to those actively at work when the policy is written. The above requirements supposedly eliminate the need for a "pre-existing-disease clause,"[8] but such a clause is found in some group policies.

In contrast to the Blue Cross "service" approach, the insurance companies generally follow the "indemnity" approach. Recent efforts have been made, with some success, by the Health Insurance Council to have insured patients admitted without the cash advance deposit usually required, and have the insurance company pay the hospital directly.[9] Even with such arrangements, however, there is a free choice of hospital. Here, as in the Blue Cross plan, the patient pays the difference, if any, between the total bill and insurance benefit. A typical policy provides a daily benefit for room and board charges during hospital confinement, and reimburses for costs of collateral hospital services, such as use of operating room, anesthesia, laboratory and X-ray examinations, and special medicines. The amounts available for collateral services are usually subject to a stated maximum. Benefits were usually limited to twenty-one days of hospitalization in the

[8] This clause, found in most individual policies, states that "this coverage does not apply to conditions existing prior to the origin of the contract."

[9] G. W. Fitzhugh, "Meeting Hospital Costs," *Accident and Sickness Insurance*, David McCahan (ed.) (Philadelphia: University of Pennsylvania Press, 1954), p. 72.

earlier policies. The trend is toward longer maximum-duration limits, so that today many policies have a seventy-day limit—others run up to 180 days or even longer. Daily hospital benefits usually vary from $3 to $15. The limit on payment of the collateral services is generally expressed as a multiple—such as 10, 15, 20 or higher—of the daily hospital benefit. Some policies are issued with absolute amounts, such as $300, or $500; still others pay everything up to $100 and 75 per cent of the next $900. The trend has been toward increasingly larger benefits.

Premium rates in hospitalization insurance vary widely between plans dependent upon the risk and expense characteristics of the group insured and upon the benefits provided in the policy. Group disability insurance is so competitive that rates vary little among companies.

The companies prefer, and often insist, that the employer share in the cost of the group disability policy. It has been the experience of the companies that the employer's interest in the insurance policy, assured by his contributions, is desirable to keep claims within expectations.

Individual Hospitalization. Individual hospitalization benefits are often provided in conjunction with other disability benefits. The past decade, however, has seen the widespread sale of separate individual hospitalization policies written primarily by casualty and mono-line accident and health companies. These policies provide cash indemnity, are written on an annual-term basis, and are usually cancellable by either party. The underwriting of these policies is often relatively lax. They are made readily available to most of those desiring the coverage. Some critics say that underwriting is done, at times, through the claims department, meaning that the policies are sold to all who apply, but that renewal will depend upon claim experience.

Benefits are similar to those provided under group policies. The daily benefits provided vary from $3 to as high as $20, with the maximum duration varying from 10 days to 365 days. Collateral hospital expenses are usually paid up to specified limits. Maternity benefits are often included. In order to combat the greater adverse selection found in individual underwriting, it has

been found necessary to impose more exclusions and restrictions than in group policies. Some of the more frequent restrictions are: pre-existing conditions, disabilities covered under workmen's compensation laws, nervous or mental disorders, self-inflicted injuries, and rest cures. Premiums vary widely with benefit provisions and are relatively higher than those for group coverage, primarily because of greater acquisition and administrative costs.

Medical and Surgical Expense Insurance. Medical and surgical expense insurance is usually written in conjunction with hospitalization benefits. It is possible also to purchase these policies separately, at least under group policies. The recent growth in this field has also been phenomenal. The number of people covered for surgical expense alone has increased fivefold in less than seven years. At the end of 1955 more than 62 million individuals were covered by surgical expense insurance alone, of which approximately 60 per cent had group policies; in addition, 26.9 million people had medical-care policies, of which approximately 75 per cent had group policies.[10] There is probably considerable duplication in these two groups.

Since there are few differences in the benefit schedules between group and individual policies, they will be discussed together. Most policies provide benefits for dependents—sometimes on a reduced scale, however. Surgical expense policies usually provide a schedule of benefits listing various surgical operations, often including maternity cases, and specifying the maximum reimbursement for each procedure. Currently the most frequently used basic schedule sets the maximum reimbursement for the most difficult operations at $200.

Medical expense insurance, in its broadest form, provides for the payment of doctors' bills other than those covered by surgical expense insurance. This coverage is usually provided under one of three general forms. The most comprehensive form provides specified payments, usually $2 or $3 for office visits and $3 to $5 for home visits, for treatment by doctors, regardless of whether or not the individual is actually disabled. There are often limits

[10] The Health Insurance Council, *op. cit.*, p. 13. These figures include dependents.

on the number of calls within a specified period. Another form provides indemnity for doctors' services only while the individual is unable to work because of disability. A third form restricts benefits to doctors' visits while the individual is in the hospital for reasons other than surgery. Usually a stated amount is paid for each visit, or a maximum reimbursement for total doctors' charges is provided according to the length of the hospital stay.

There are many special policies that provide comprehensive reimbursement of all expenses, arising from accidental injuries, or from poliomyelitis, or from groups of "dread diseases." These policies have been issued without deductibles, without any special limits as to each type of charge, but with some over-all limit such as $3,000 or $5,000 per each occurrence.

A more recent coverage, similar to the above, is major medical expense, or catastrophe, insurance. This policy pays all hospital, surgical, medical, nursing, and drug expenses above a stated deductible, often $500, up to a maximum limit such as $3,000, or $5,000. A unique feature is that there is usually a coinsurance provision that limits the insurers' payments to 75 per cent of the actual expense incurred by the policyholder. This feature is intended to curb excessive utilization.

INCOME-REPLACEMENT INSURANCE

As has been brought out in the first chapter, there are many costs resulting from temporary nonoccupational disability. One of the most important of these, and the most important for the purpose of this study, is the loss of wages by the victim of the disability. There have been many organized attempts to cope with this hazard voluntarily, including commercial and co-operative insurance, and wage continuation programs. Some of the plans have combined medical-care benefits, of one kind or another, with the weekly wage indemnity provisions. Emphasis, nevertheless, has been on the latter.

Commercial Insurance

Individual Accident and Health Insurance. The first policies, providing protection only against railway accidents, were written

in America about 1850. Accident policies with broader coverage came later, and still later health benefits were added. The first separate health policy was not issued until almost half a century after the first accident policy.[11] Competition in this field has been intense and regulation has been relatively mild, one outcome of which has been the great diversity of policy forms issued. A survey conducted a few years ago indicated that there were over 800 forms in use. As long ago as 1909, efforts were made to effect some uniformity in accident and health policies. Many states now have statutes requiring certain standard provisions in these policies, but there is still much leeway for diversification.

Temporary disability benefits for individuals are obtainable in several different types of policies. Widely sold is the "limited" policy, so called because protection is usually severely limited as to time or kind of hazard insured. Common examples of these policies are the aviation-ticket policy, the automobile-accident policy, and the newspaper policy. Large potential maximum benefits promised for small premiums largely account for their wide sales. The chief disadvantage of limited accident policies of any kind is that the insured is apt to overvalue his protection. Consequently, great disappointment and dissatisfaction result when an accident occurs that is not covered under the policy.

The *industrial* disability policy affords some protection against sickness and accident to many of the same groups who secure industrial life insurance policies. However, most of the industrial disability insurance sales are restricted to the South and Southwest. Premiums are collected either weekly or monthly, and the business is conducted in much the same manner as in industrial life insurance. The policies are restricted in scope of benefits and are written for small amounts.

The *noncancellable* policy is unique in that it specifies that the company cannot cancel, so long as premiums are paid, until the insured reaches a designated age, usually sixty years. This policy, other things being equal, provides the most reliable coverage in the field; but, as for most superior products, the price is high. In

[11] C. A. Kulp, *Casualty Insurance* (New York: Ronald Press Co., 1956). See Chap. XIV for more detail on the history of accident and health insurance.

addition to the relatively high cost, stricter underwriting standards are imposed. In an endeavor to keep the costs as reasonable as possible, these policies have been offered with relatively long waiting periods, often as long as ninety days. Some policies provide death benefits and other specific benefits, but the important benefit is the weekly indemnity for total disability. In the earlier forms weekly indemnity was payable for life; but many policies today limit the period for which benefits are available to a fixed term of years, or limit the aggregate amount that will be paid.

The greatest volume of individual voluntary insurance granting cash indemnity against loss of time is provided by the *general* or *commercial* accident and health policy. In 1955 approximately 14 million individuals were provided some degree of protection against loss of income by these policies.[12] They are cancellable at the will of the company, or at best, subject to renewal each year at the discretion of the company. This provision has given rise to much justifiable criticism since it is possible for the policy to be cancelled when needed most. Cancellation, however, is without prejudice to a claim originating prior to such notice. These policies, when written by reliable companies, are restricted primarily to individuals with a steady income and of high moral character. Protection is usually provided against total and partial disability arising from accident and sickness; it is seldom, however, that policies are sold to protect against sickness alone. When both hazards are covered in the same policy they are usually treated differently as to waiting periods and duration of benefits.

A waiting period of one to four weeks is almost always required before benefits are paid for disease. This waiting period, on the other hand, is frequently waived if disability is due to accident. The primary benefit is weekly indemnity of lost earned income; some policies, however, provide a variety of other benefits, such as a principal sum in the event of accidental death, dismemberment benefits, and medical expense indemnity. Historically, accident and health insurance has had the reputation of

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[12] The Health Insurance Council, *op. cit.*, p. 25.

having an excessive number of exclusions. Reputable companies today limit their exclusions to the aviation hazard, self-inflicted injuries, hernia, and a few other reasonable restrictions.

Individual accident and health policies are relatively expensive. High acquisition costs are a primary factor here. As much as 50 to 55 per cent of the total premium is allowed for loading, with acquisition cost being the chief factor, which is a serious deterrent to wide coverage.[13]

Group Accident and Health Insurance. The early history of group accident and health antedates all other group insurance, but it was not until the early 1920's that it had wide acceptance. Growth in the past decade has been considerable. At the end of 1955 there were 19.2 million individuals with group protection against loss of income due to disability.[14] This insurance is often sold in conjunction with group life and other disability coverages.

These policies pay weekly income benefits under a one-year term policy for loss of time due to nonoccupational sickness and accident. The contract is usually made with the employer or an association. By company preference, and statute in some states, ten is usually the minimum-sized group. In an effort to restrict selection, it is required that a certain minimum percentage of the group must be insured when the plan is contributory. No medical examination is required unless an employee fails to apply for the insurance within thirty-one days after he is eligible. To eliminate temporary employees, a period of from one to six months is usually required before employees become insured.

The cost of the insurance is usually shared by the employer and employees. A recent trend is for the employer to pay the entire cost, but in a few cases the employees pay all. Premiums for the same benefits vary with the size of the group, proportion of women, and the proportion of non-Caucasians. If the age distribution is abnormal, it, too, is considered. Since this is insurance

[13] See C. A. Kulp, *op. cit.*, pp. 391–98 for a critique of accident and health insurance.

[14] The Health Insurance Council, *op. cit.*, p. 25.

against nonoccupational accident and sickness, only those groups subject to an exceptional industrial health hazard are rated.[15] Premiums are usually subject to experience rating.

Benefits are paid for total disability resulting from a nonoccupational injury or illness certified by a physician. Some plans offer flat benefits for all, but it is more common to pay a certain percentage (two thirds) of wages, subject to a maximum amount. The maximum duration for benefits is usually thirteen or twenty-six weeks, with a few plans covering up to fifty-two weeks. There is often a seven-day waiting period, which is sometimes eliminated for disabilities caused by accident.

Co-operative Insurance

Co-operative disability insurance has had widespread adoption in Europe. Many groups that emigrated to America inaugurated similar plans here. These have been restricted, primarily, to low-income groups. For a variety of reasons, such plans have not been popular in America. It was estimated in 1953 that after more than seventy-five years of operation less than two million people had protection under this type of insurance.[16] Weekly benefits are usually small. Co-operative insurance is represented primarily by fraternal benefit societies, employee mutual benefit associations, and trade-union benefit associations.

Fraternal Benefit Societies. These organizations provide their members with a relatively large amount of life insurance; in addition, many also provide total and permanent disability benefits. Relatively few, however, grant a benefit for temporary disability.

A probationary period of membership in the organization is usually required in order to qualify for coverage in the disability plan. There is little uniformity in benefit amounts, but they are usually low. Some societies reduce benefits after a certain number of weeks of disability. Duration of benefits ranges from six to twenty-six weeks. Small benefits and economical administration

[15] This extra premium is charged primarily because of the difficulty in determining whether or not a disease is of occupational origin. Consequently, many claims are made against the insurer of the nonoccupational health hazard for disability that is primarily due to working conditions.

[16] The Health Insurance Council, *op. cit.*, p. 25.

permit low premiums. The decreasing need for the social function of these societies, inadequate benefits, and actuarial deficiencies have discouraged new memberships.

Employee Mutual Benefit Associations. The development of these groups took place largely before the passage of workmen's compensation laws, and arose from the need for some protection against the disability hazards of an industrial economy. The prevalence of workmen's compensation and group disability insurance has contributed to the decline in membership of these groups.[17] The total membership of these associations in 1955 was estimated at less than one million.[18]

Employee mutual benefit associations usually have had very low administrative expenses, largely because of labor contributed by members and employers. The feeling of comradeship and ease of checking on claims has practically eliminated malingering. Employers usually contribute to the cost of these plans, and when they do, they also participate in the management.

The primary benefit provided by these associations has been a weekly cash indemnity, but to an increasing extent, medical benefits are being provided. Nominal benefits are, in most cases, uniform in amount. Benefit durations vary, the most usual being thirteen or twenty-six weeks. A few associations pay benefits immediately upon the inception of disability, but most insist upon a seven-day waiting period. Disabilities of occupational origin are usually excluded, as are those resulting from intemperance, use of narcotics, fighting, and immoral conduct.

Trade-Union Associations. Whereas the mutual benefit associations were organized for the purpose of providing disability benefits, labor unions have focused their attention on increasing wages, improving working conditions, and reducing hours of work. In keeping with these objectives, many unions have promoted preventive efforts, but few have provided disability benefits for their members. In recent years especially, unions have endeavored to gain disability benefits for their members by nego-

[17] H. Ladd Plumley, *Budgeting the Costs of Illness* (National Industrial Conference Board, 1947). See chap. iv for the history of these associations.

[18] The Health Insurance Council, *op. cit.*, p. 25.

tiation; these benefits, however, have in most cases been provided by commercial insurers, rather than by the unions themselves. Union-administered plans were estimated to have provided loss-of-income disability benefits to less than one million members in 1955.[19]

Disability plans inaugurated by unions have not been as successful as those of mutual benefit societies, due to the secondary interest of the union leaders in the plans, and also to the conflict in interest of the local and national groups. Most unions having disability plans have been national unions. When the function of certification of claims has been entrusted to local leaders, there has been a tendency for lax administration since "the money comes from the national treasury anyway."

Many unions providing disability benefits made membership in the plan compulsory. Premiums were then set aside from regular dues. Small weekly benefits were provided, subject to many of the same provisions (such as waiting periods, duration, exclusions, and so forth) as were discussed in relation to the mutual benefit societies.[20]

Wage-Continuation Plans

While wage-continuation plans do not qualify as insurance, they often substitute for the latter and are discussed here briefly. Some employers continue to pay wages, or a fraction thereof, to employees who are temporarily disabled. This may be either an informal practice or a contractual agreement. Most of the contractual wage-continuation plans are for civilian governmental employees. In 1955 it was estimated that 4.8 million civilian employees of governmental bodies were protected by wage-continuation plans, while 3.1 million employees of private industry had similar protection.[21]

There is little uniformity among these plans. It is usual to pay full wages for one to four weeks followed by a period at half

[19] *Ibid.*, p. 25.

[20] Elizabeth L. Otey, *Voluntary Disability Insurance* (Washington, D.C.: Social Security Board, 1940), chap. v.

[21] The Health Insurance Council, *op. cit.*, p. 25.

wages, depending upon the employee's length of service with the firm. It is not uncommon in industry to restrict these benefits to salaried personnel.

POSSIBILITIES OF FUTURE GROWTH IN VOLUNTARY COVERAGES

Barring any substantial economic reverses, it is to be expected that voluntary disability insurance will continue to expand. For the past three decades there has been a continuous upward trend in growth of both group and individual coverages. On the other hand, it is not reasonable to expect that the past rate of growth will be maintained. There are many obstacles that will prevent the achievement of practically universal coverage on a voluntary basis.

One of the most important factors impeding future growth is that the most likely candidates for voluntary insurance are already successfully covered. Several surveys have established, for example, that the percentage of coverage is much higher among large than small firms.[22] Contributing to this has been the inclusion of disability benefits as a feature of collective bargaining, which is engaged in by more large than small firms. Insurance companies have contributed to this by concentrating on larger firms. More attractive plans have been offered large groups because of savings in acquisition and administrative expenses; in addition, many state laws have restricted group sales to groups of twenty-five or larger.

The past decade has been an exceedingly profitable one for most American businesses. If firms have failed in this boom period to inaugurate disability plans because of the cost, it may reasonably be assumed that they will not consider any period more auspicious in the near future. The same reasoning is pertinent with reference to the future growth of individual coverages. The past decade has also been one in which organized labor has had

[22] New York Department of Labor, *Studies in Disability Insurance* (1949), p. 67.

a considerable voice in determining wage levels, including disability benefits. Labor may never be more influential.

The extent of coverage by voluntary insurance has proven in the past to be sensitive to economic conditions. If a recession occurs, the extent of voluntary disability insurance may decline sharply, although group accident and health insurance maintained its volume very well during the depression of the 1930's. Individual disability insurance, in contrast, suffered a drop of some 40 or 50 per cent.[23]

Other factors that will tend to condition future growth of voluntary coverages are: inability of many industries to qualify for underwriting reasons (high percentage of women, abnormal hazard, and so forth), administrative reasons (employments characterized by high turnover, such as longshoring), and financial reasons (inability to meet costs).

While at the end of 1955 there were approximately 48 million workers in this country with some voluntary insurance against medical-care losses, there were less than 38 million with protection voluntarily provided against the greater hazard, i.e., loss of income due to disability.[24] This means that approximately two fifths of the working people in the United States have no voluntary disability-income protection whatsoever. And the likelihood of a large proportion of this group acquiring such protection in the near future is remote. The growth of voluntary disability income protection during the past few years has been slight. For example, there was a slight decline in such coverage during 1952, and the 1953 totals represented but a 0.4 per cent increase over totals for 1951. However, the increases exhibited during 1954 and 1955 were somewhat greater.[25]

The prospect then, barring economic recession, seems to be a very modest extension of voluntary disability-income coverage; nevertheless, there will always be many for whom protection against loss of income will not be provided voluntarily.

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[23] H. A. Millis, *Sickness Insurance* (Chicago: University of Chicago Press, 1937), p. 23.

[24] The Health Insurance Council, *op. cit.*, pp. 23, 25.

[25] *Ibid.*, p. 25.

NEED FOR LEGISLATION

The question of the necessity of compulsory temporary disability insurance involves a twofold problem: first, whether there is a need and a demand for disability insurance; second, whether that need can adequately be met by present disability plans.

Need and Demand for Disability Insurance

The need for some type of systematic protection for wage earners against the hazard of lost income has been widely recognized. The heavy financial burden of disability, which falls with greatest impact upon the low-income groups, has long been one of the most important factors leading to public dependency. For the individual wage earner this major hazard is unpredictable, both as to its timing and its severity. For large groups, however, it is reasonably predictable and can be insured.

The need has long been recognized by private industry and has given rise to the demand for insurance protection. As brought out earlier in the chapter, millions of workers have some degree of protection against the disability hazard, due primarily to the efforts of employers. Labor leaders have recognized this need and have often insisted on including it as a topic for union-management negotiation.

The Case for Legislation

Despite widespread recognition of the need for disability benefits, the need for compulsory legislation has not been generally recognized in this country. There are still those who believe that various types of voluntary individual or group plans are adequately meeting the need for protection against the disability hazard, or, in any case, that compulsory insurance has so many dangers it must be avoided. But at the present time only slightly more than three fifths of the working population have protection of any kind voluntarily provided against the loss-of-income hazard; and some of these have inadequate protection.

Numerous studies have shown the inadequacy of existing voluntary coverage. A study conducted in New York State shortly after World War II by the National Industrial Conference Board concluded that, depending on types of program, voluntary sickness benefit programs covered from a minimum of 29 per cent to a maximum of between 40 per cent and 50 per cent of all workers covered by New York's Unemployment Compensation Law.[26] A study in Massachusetts in 1946 indicated that 36 per cent of the workers had no protection against nonoccupational disability. Many question the accuracy of the figure and believe that the estimate exaggerated the coverage.[27] A Louisiana survey in 1950 showed that only 27 per cent of the industrial workers reported in the survey were protected by company-sponsored disability insurance. And "because of apparent misunderstanding [of the survey], this is a maximum figure."[28] An Ohio survey disclosed that, as of December, 1949, an estimated 52 per cent of persons covered by Unemployment Compensation in Ohio belonged to plans which would pay cash benefits in the event of nonoccupational disability.[29] Other studies have presented a similar picture. Most of the studies exaggerate the proportion of coverage since workers employed in agriculture, domestics, and employees of small firms were not surveyed, most of whom would probably have been found to have little or no coverage.

Governments have recognized the need for legislation. Four states and the federal government have enacted legislation providing cash benefits for over ten million workers, in the event of temporary disability of nonoccupational origin. Many other states have appointed study commissions and considered similar legislation.

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[26] National Industrial Conference Board, *Compulsory Sickness Compensation for New York State* (New York, 1947), p. 172.

[27] Commonwealth of Massachusetts, House, *Report of the Special Commission Established to Make an Investigation and Study Relative to the Establishment and Administration of Cash Sickness Compensation*, House Report, No. 2575 (1950), p. 17.

[28] L. V. Howard, *Temporary Disability Insurance* (Louisiana Department of Labor, 1950), p. 19.

[29] Edison L. Bowers and Sam Arnold, *Cash Disability Benefits in Ohio* (Columbus: The Ohio State University, Bureau of Business Research, 1952), p. xxv.

Federal and state governments have already provided some measure of protection against other economic hazards to which most citizens are subject: loss of income due to industrial injury, old age, death, and unemployment. To some extent these are lesser hazards than that of nonoccupational temporary disability. Many feel that the one large gap in a comprehensive social security system is that of temporary loss of earning power arising from nonoccupational disability, and they feel that this gap should be filled.

As stated by the New Jersey State Commission on Postwar Economic Welfare:

> Popular opinion also overwhelmingly favors the extension of some form of social security legislation to protect against the hazards of illness. Particularly in the lower income levels, where the frequency of non-occupational illness seems to be greatest, people suffer most severely from the economic effects of wage loss. Since it is an accepted public policy to protect the individual against wage loss caused by involuntary unemployment, it seems desirable to fill the gap in this protection by meeting the hazards of inability to work caused by sickness. The public interest in social and economic security and stability is as much served in the one case as in the other.
>
> While the progress made in supplying protection against wage loss caused by illness through voluntary programs adopted by employers has been great, the need for the extension of such protection is so great as to warrant the establishment of some form of uniform minimum standard coverage. Given sufficient time the voluntary programs might very well be extended greatly, but there would always remain a significant number of people for whom either no provision has been made or for whom inadequate provision has been made. The establishment of a minimum standard and its enforcement is essentially a function which must be performed by government, in whatever manner benefits may be provided. It remains to determine the best method by which such minimum benefits may be provided and financed.[30]

A statement by Mary Donlon, Chairman of the New York Workmen's Compensation Board, further emphasizes this need.

> The need to provide some form of cash income when the family wage earner is disabled as the result of an accident or sickness not connected

[30] New Jersey State Commission on Post-War Welfare, *Cash Sickness, Benefits* (Trenton, 1946), pp. 9–10.

with his job, has long been a serious gap in our social insurances. Those who live a week-to-week existence, with no income other than the paycheck, are never free of anxiety—almost a nightmare—as to what to do when the breadwinner becomes disabled while living expenses continue, medical care becomes imperative, yet there is no income in sight. Wage loss resulting from injury or illness of a non-occupational origin is a significant cause of the high cost of public assistance, since lack of insurance protection forces many workers to turn to public relief authorities when they are disabled. Some system must be worked out and embodied in legislation which will insure wage earners against total loss of income when they are unable to work for an extended, though temporary, period because of illness or accident.[31]

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[31] From an address before Interstate Conference on Non-Occupational Disability Benefits Programs, December 15, 1949.

PART · II

History

CHAPTER · 3

Brief History of Compulsory Temporary Disability Insurance in Europe

It has been said that while the wise man learns by experience, the wiser man learns by the experience of others. Since experience with compulsory temporary disability insurance in the United States has been limited, it is useful to observe European data in this field. The principle of obligatory insurance was first clearly established in Prussia by law in 1854, and many European countries have had compulsory systems for over forty years. While knowledge of European experience may aid in the analysis of American plans, the limitations of this information for our use should be noted. Each plan was developed in light of the social background and economic potential of the country, to meet the needs of a specific group. No one European plan could be adopted here without drastic modification. On the other hand, the experience and trends developed there may well be helpful in shaping our legislation. While our systems emphasize cash benefits to insured workers, it is of interest to note the continued increase in scope, i.e., benefits other than cash, of European benefit provisions.

Compulsory disability insurance has been, historically, confined to the working population. European systems have been called "poorman's systems."[1] Increasingly, however, insurance has been extended to broader groups of wage earners. Often the right to elect coverage has been accorded persons outside the compulsory provisions of the law, provided their incomes do not exceed a certain specified amount.

[1] I. S. Falk, *Security Against Sickness* (New York: Doubleday, Doran & Co., 1936), p. 66.

Benefits under European disability programs consist of compensation for loss of income and medical-care benefits in all programs, and maternity and funeral benefits in most. Cash benefits at flat rates, or at a proportion of wages, are paid the eligible worker while disabled. There are usually waiting periods, ranging from a few days to a week, with the maximum duration periods varying from thirteen to fifty-two weeks. While compensation is only partial, it is designed to provide the insured and his dependents with the essentials for maintenance without becoming charges upon others. Provisions for medical care are often comprehensive. In many countries dependents have the same, or substantially the same, rights to medical care as the insured. Medical service is furnished, in most cases, by private practitioners who are remunerated from the insurance funds. For the most part, insurance is the method of compensating for losses arising from disibility. "State medicine" or "public medicine" is not necessarily a part of the system.

Funds required to finance the disability insurance plans are obtained primarily from contributions by employees and their employers. In most cases, the public treasury pays only a small portion of the costs of disability insurance. Taxes, however, are used for the support of hospitals which otherwise would need to make higher charges for services to insured members. Hence, there is an additional, hidden, government subsidy.

Administration of these plans, though supervised by the respective governments, has traditionally been in the hands of nonprofit associations of insured persons. Profit-making organizations have little place as insurance carriers. A partial exception was found in Great Britain where the industrial (commercial) companies were formerly permitted to qualify and to operate along with the "friendly societies," provided they established nonprofit departments for compulsory disability insurance.

A more complete and accurate evaluation of European experience can be gained by considering in more detail some of their systems, whose basic features have been stated above. Germany and Great Britain have been the pioneers, consequently their experience will be emphasized.

COMPULSORY DISABILITY INSURANCE IN GERMANY

The German system of compulsory disability insurance dates from 1883 when Bismarck put into operation a federal law making such insurance compulsory for all industrial workers. But that law was an evolutionary development, not a revolutionary step. The idea of mutual help can be traced back to the guilds of the Middle Ages. The Prussian Code of 1794 specifically recognized and regulated artisans' guilds, journeymen's unions, and miners' associations for mutual aid.[2] The same code, some fifty years later, empowered local authorities to require certain groups to join mutual benefit organizations for financial protection against sickness, need, and death. Later, laws were passed authorizing local governments to require factory owners and master craftsmen to insure their workmen against sickness. Similar developments had taken place in other German states, so that by 1883 thousands of mutual associations were providing sickness benefits for several million persons. Federal action was mainly an extension and a standardization of current local practice.

The Act of 1883 made membership in disability insurance organizations obligatory for industrial wage earners and salaried workers whose incomes did not exceed a specified figure. The result of successive liberalizing acts was to increase greatly the numbers insured under such compulsory plans. By the late 1920's approximately two thirds of all those gainfully employed were covered. In addition, many dependents had acquired rights to supplementary benefits.[3]

Benefits, as previously indicated, are of two types; cash and medical care. The latter is a very inclusive health service. The most important cash benefit is for loss of time from the insured's occupation. It consists of 50 per cent of the basic wage, subject to a maximum, after a four-day waiting period. Originally limited to thirteen weeks, the maximum duration was later raised to

[2] C. A. Kulp, *Social Insurance Coordination* (Washington, D.C.: Social Science Research Council, 1938), p. 76.

[3] Falk, *op. cit.*, pp. 78–80.

twenty-six weeks in the year. Cash is also provided for funeral and maternity benefits. In addition to the minimum benefits prescribed by law, optional benefits are permitted when financial circumstances warrant them and federal authorities approve.

During the forty-five years of experience from 1885 to 1929, the cost of cash sickness benefits steadily increased from 5.5 to 32.6 marks per member. This was the consequence of a rising price level, voluntary increases in contributions, cash benefit increases, liberalization of maximum durations, and the addition of women and other "less desirable" risks. Despite the liberalization of cash benefits, they constituted a decreasing proportion of total costs. Whereas cash benefits once consumed nearly one half of total expenditures, in 1929[4] they took less than one fifth.

Contributions to the funds are in the proportion of two thirds by the insured and one third by the employer. The government makes no contribution, other than providing supervision of the insurance societies. Contribution rates vary by funds, but average between 5 and 6 per cent of earnings.

Societies admitted as statutory insurance carriers administer the insurance program. Each operating on its own, these societies are democratically managed by committees of employers and employees elected by the membership. The law allows the societies broad discretionary powers. Commercial insurance carriers are not admitted.

COMPULSORY DISABILITY INSURANCE IN GREAT BRITAIN

The British system of compulsory disability insurance contrasts markedly with the German system. The history of legislation in Great Britain started about one hundred years after its German counterpart. The first compulsory disability insurance law in Britain was passed in 1911. National legislation was not preceded

[4] H. A. Millis, *Sickness and Insurance* (Chicago: University of Chicago Press, 1937), p. 64.

by local legislation, as it was in Germany. The British plan was influenced by, but not patterned after, the German legislation. Developments in the two countries have taken divergent pathways and continue to be distinct.

Prior to 1911, many friendly societies, trade-unions, sick clubs, and employers' provident funds provided disability insurance on a voluntary basis. They were nonprofit institutions whose primary objective was to provide protection against loss of wages due to disability. They also provided some forms of medical care, as well as cash benefits. When the British established their compulsory system in 1911, they found it desirable to incorporate these various organizations into their system. As the industrial (commercial) insurance companies were politically powerful, they successfully demanded that the law also permit them to qualify as nonprofit insurance organizations by setting up special nonprofit departments for compulsory disability insurance. Thus, for thirty-five years the British system was operated by two types of organizations—the friendly societies and the commercial companies.

A revolutionary change was made in the British program after World War II. In 1946 the National Insurance Act (to provide cash benefits) and the National Health Service Act (to provide medical care) were passed; the former was consolidated with unemployment insurance and old-age retirement. The changes vested complete operation and control of the disability scheme in the hands of the central government, eliminating the friendly societies and industrial companies. It is believed, however, that many of the societies will continue to provide supplementary benefits and to serve other social needs.[5]

The coverage of the original British law was more inclusive than were the first German laws. In Great Britain the law embraced all persons between sixteen and sixty-five years of age engaged in manual labor under a contract of service, and nonmanual workers earning less than a specified sum. Few employments were exempted. The laws were gradually liberalized until shortly be-

[5] William Beveridge, *Voluntary Action* (New York: Macmillian Co., 1948), chap. 10.

fore World War II, approximately 80 per cent of all gainfully employed persons were covered. The National Insurance Act (cash benefits) now covers employed and self-employed men between the ages of sixteen and sixty-five, and women between the ages of fifteen and sixty except that coverage is extended to ages 70 and 65 respectively for those persons who continue working to such ages. Coverage is not compulsory for nonemployed persons with income of less than £104 per year, nor for employed married women.[6]

The cash benefit schedule of the British system differs from that of the German system. Cash benefits in Great Britain are flat amounts (varying only by sex and dependency status of the claimant), whereas in Germany benefits are proportional to income. Flat benefits inevitably mean that in the majority of cases benefits are small compared with wages, for they cannot be fixed at more than a fraction of the wage of lowly paid labor. This also means there should be a large demand for voluntary insurance to supplement the statutory benefits.

Nominal loss of time benefits are paid after a waiting period of three days. Whereas formerly limited to a maximum of twenty-six weeks, they are now paid for the duration of the disability. A cash maternity benefit is available. A cash funeral benefit was added by the National Insurance Act. Extensive medical-care benefits are available under the National Health Service Act.

Employers pay a smaller contribution than do employees, with the government contributing a still smaller proportion. Contributions are flat rates, although women and workers under eighteen years of age pay reduced amounts, presumably because of their inability to afford the higher rates.

Cash benefits are now administered by the Ministry of National Insurance, with the Ministry of Health administering medical benefits. Prior to 1946, cash benefits were administered by the friendly societies, while Insurance Committees, subject to the Minister of Health, administered medical benefits.

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[6] Much of the data on the recent laws are from: Federal Security Agency, *Social Security Legislation around the World*, Bureau Report No. 16, Third Supplement (1953).

OTHER COUNTRIES

Germany and Great Britain have been pioneers in the field of compulsory disability insurance. The example was set as early as 1883 in Germany; but the idea spread slowly and it was not until after World War I that it gained momentum. Today forty-three countries, excluding the United States, have some form of compulsory disability insurance usually covering all male wage earners regardless of income.[7] Workers in the higher-earnings groups often are not obliged to insure, but may do so voluntarily. Most countries have increasingly broadened coverage.

The original intent of most compulsory insurance programs was to provide a substitute for wages lost due to disability. The vast majority of existing plans still provide a cash benefit, usually a percentage of average wages, subject to a maximum and a minimum. The more important and costly benefit, however, is medical care. Nevertheless, all plans, except those of a few Latin American countries and Turkey, now provide medical care. Practically every plan provides for the transfer of the claimant to other insurance plans upon exhaustion of temporary disability benefits. Nearly all plans provide medical-care benefits as well as maternity benefits for dependents. Many countries, particularly in Central Europe, also provide a funeral benefit.

Approximately 60 per cent of the plans are financed jointly by employer, employee, and the government. The government's contribution is often limited to administrative expenses. Approximately 17 per cent of the plans are financed exclusively by employers and employees, but this small number includes four important European countries (Germany, France, Italy, and Austria). A few plans limit financing to the employers; some limit it to the employer and the government; while others limit financing to the employee and the government. No plans are financed by the employee alone, nor by the government alone. Since benefits vary widely and contributions often include provision for other than

[7] Data in this section are from Federal Security Agency, *op. cit.*

disability insurance, it would be difficult to generalize on rates of contribution.

In 70 per cent of the plans insurance is provided by a governmental insurer, in 19 per cent of the plans insurance is provided by private co-operative (nonprofit) organizations, while 11 per cent permit the choice between governmental or private carrier. In no plans are commercial insurance companies permitted to participate. The private organizations are usually sick clubs, guilds, or employee groups such as are found in Germany.

SUMMARY

Inasmuch as the social and economic backgrounds of the United States and Europe are very different, the latter's experience with disability insurance will probably not be duplicated here. Nevertheless, the trends in European development may serve as a guide for us.

All European plans have, in the course of development, greatly broadened their coverage. Plans originally designed for the laboring classes have been expanded to include almost all workers. Provision for dependents also has generally been added. While cash benefits have usually increased in amount and in maximum duration, they have tended to represent a decreasing proportion of total cost. Most plans have initially included limited medical-care benefits, but subsequent liberalizations have provided more comprehensive care. This trend has progressed, at times, to the point where the cost of other-than-cash benefits constitutes 80 per cent of total expenditures.

Many plans permit operation of private organizations with supervision by the central government. However, commercial insurance companies have usually been excluded. Employers and employees have most often contributed equally to the financing of disability insurance, with the central government bearing a small share of the costs. Broader coverage and increased benefits, in conjunction with greater utilization, have tended to considerably raise costs per member over the years.

CHAPTER • 4

Historical Background of Compulsory Temporary Disability Insurance in the United States

WHILE compulsory temporary disability insurance in the United States is of recent origin, attempts to pass such laws were made as early as forty years ago. Proposals have been made at the federal level as well as at the state level.

EARLY LEGISLATIVE ATTEMPTS

In December, 1912, a National Committee on Social Insurance was created by the American Association for Labor Legislation, to foster social health insurance investigation and promote legislation at the state level. In 1915, with the help of a committee of the American Medical Association (a strange alliance in view of recent history), it drafted a model health insurance law that was known as the "Standard Bill." This bill, or an adaptation of it, was introduced in three states in 1915, and in twelve states in 1917. As a consequence of the interest aroused, many states established investigating commissions, several of which reached favorable conclusions; one declared adversely. No bill was passed in any state, however. "The case for compulsory health insurance [was] fully made up by the eleven reports of official state commissions. It seldom happens that the evidence is so overwhelmingly one way."[1]

Much of the impetus for the American movement stemmed from the passage of the British Insurance Act of 1911, but the

[1] John A. Lapp, "The Findings of Official Health Insurance Commissions," *American Labor Legislation Review*, March, 1920, p. 40.

"Standard Bill" was patterned largely after the German model. The major provisions of the "Standard Bill" are of interest. Nonprofit societies were to be established as insurance carriers, and the financing of the scheme was to be borne by the employer, the insured, and the state. Coverage was to extend to all manual laborers (except casual and domestic) earning less than a specified wage. Minimum benefits included medical-care, maternity, funeral benefits, and cash to compensate for lost time due to disability.[2]

The principal opposition to these bills came from commercial insurance companies, employers' organizations, the medical profession,[3] and Christian Scientists. The labor movement was divided on this issue. Many influential labor leaders voiced their personal opposition, which was often more effective than the endorsements given by the union bodies. The following excerpt summarizes the reasons for the failure of the health insurance movement:

> Much of this (opposition) has been due to the nature of the movement, and much to the mistakes of its advocates. . . . Perhaps these mistakes may all be summarized in a brief sentence: over-enthusiasm, based upon implicit faith in the justice and social value of the measure; and last but not least, failure to recognize the various class and group interests involved.[4]

FEDERAL ACTIVITY

Interest in disability insurance was at a low ebb in the prosperous twenties, but the depression revived interest and renewed activity in the field. The passage of the Social Security Act, in 1935, stimulated discussion of disability insurance legislation; no proposals, however, were made to include disability insurance in that fundamental law. This omission was due in part to the efforts

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[2] "Tentative Draft of an Act," *American Labor Legislation Review*, June, 1916, pp. 239–68.

[3] Despite the early backing by the American Medical Association, many local medical organizations opposed the movement. In 1920 the AMA officially went on record as opposing such bills.

[4] I. M. Rubinow, *The Quest for Security* (New York: Henry Holt & Co., 1934), p. 210.

of insurance companies and the medical profession. The opposition of the latter group was particularly persistent and intense.[5]

In recent years several bills containing provisions for both cash and medical-care benefits have been introduced in Congress. In 1939 a bill was introduced to authorize subsidies to states enacting approved plans for temporary disability compensation. Two years later a similar bill was introduced which provided for the establishment of state systems of disability insurance aided by federal subsidies and subject to Social Security Board approval. The following year a series of amendments to the Social Security Act were proposed, one of which included provision for cash benefits for disability payable on the same basis as unemployment compensation.

In 1943, the Wagner-Murray-Dingell Bill was introduced to establish a comprehensive system of social insurance on an exclusively federal basis. It would have provided complete medical-care, maternity, and permanent disability benefits, as well as cash compensation for temporary disability payable on the same basis as unemployment compensation. The bill was widely discussed but failed of enactment. Presidential messages to both the 79th Congress and the 80th Congress contained requests for comprehensive disability insurance to assure "that the people of America be protected against loss of earnings due to illness or disability not connected with their work."[6]

The Serviceman's Readjustment Act of 1944 provided cash benefits for unemployed veterans even though disabled. A veteran eligible for unemployment benefits under the Act, who subsequently became incapacitated, continued to receive unemployment benefits despite his inability to work. This is in contrast to most state unemployment laws which require that the claimant be able and willing to work, thus disqualifying the disabled unemployed worker.[7]

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[5] Eveline M. Burns, *Toward Social Security* (New York: Whittlesey House, 1936), p. 150.

[6] Interstate Conference of Employment Security Agencies, *Sick-Pay Benefit Legislation* (Helena, Mont.: Naegele Printing Co., 1948), p. 66.

[7] See "Disability Benefits for Unemployed Workers," Chapter 8, for a discussion of this concept.

In 1946, amendments to the Railroad Unemployment Insurance Act were introduced in Congress adding provision of cash benefits during temporary disability. Benefits first became payable July 1, 1947. It was felt that the unemployment insurance reserve fund was large enough to pay both unemployment and disability benefits without raising the contribution rate. Benefits are paid out of the Railroad Unemployment Insurance Account, which arises from a payroll tax paid entirely by employers. The Act provides for a monopolistic governmental fund. In fact, it represents simply an extension of the unemployment insurance system to cover periods of unemployment due to disability. This law differs from the Serviceman's Readjustment Act provision in that the worker with a job but unable to work because of temporary disability is eligible for benefits. This legislation represented the first disability insurance enacted at the federal level. It is believed that these laws stimulated support for state disability legislation from those groups opposed to increasing federal governmental activities. The Act is discussed in more detail in later chapters.

The unemployment compensation provisions of the Social Security Act of 1935 had a considerable, though unintended, influence on the development of subsequent state disability laws. The depression in the early 1930's gave rise to a widespread demand for unemployment compensation. Congress wanted to institute a federal unemployment compensation system but had doubts as to its constitutionality. As an alternative, a provision was included in the Social Security Act to induce the states to set up their own unemployment compensation systems. The device used was a payroll-tax levy on all employers of eight or more persons.[8] It also provided, however, that the employer would receive a 90 per cent credit on the federal tax if his state passed an unemployment compensation law eligible under federal standards. The remaining 10 per cent of the federal tax was to be used by the federal government, through the Social Security Administration, to finance the administrative expenses of the state unemployment compensation systems. This tax-credit inducement achieved the desired result and every state enacted qualifying legislation.

[8] The tax is 3 per cent of salaries and wages up to $3,000 annually.

Unemployment compensation legislation had a multiple effect upon the development of state temporary disability insurance laws. The first, and most important, was that some states, in addition to the tax levied upon employers, taxed employees.[9] Eight states taxed employees 1.0 per cent of wages or less; Rhode Island, however, imposed a tax of 1.5 per cent.[10] Subsequent to the passage of legislation, unemployment was relatively low, permitting large unemployment insurance funds to accumulate. The size of these funds induced a number of states to repeal the requirement for employee contribution; but Rhode Island, California, New Jersey and Alabama continued their tax on employees.[11] High employment during the war years further increased the size of the funds. These large funds, plus the fact that in most states unemployment compensation was paid for entirely by employers, gave rise to activity on the part of labor to divert employee contributions to finance a disability insurance program.

The movement was given further impetus by the passing of the Knowland Amendment, in 1946, by Congress. This amendment permitted those states that had at any time levied an unemployment compensation tax upon employees to use the funds that had accumulated from this source to finance temporary disability insurance benefits. Alabama, California, New Jersey, and Rhode Island were most affected by this Act since they had taxed employees for the longest periods of time. Rhode Island was credited with a total of approximately $29,000,000; California with $315,000,000;[12] New Jersey with $182,000,000; and Alabama with $25,000,000.

Another way in which unemployment compensation hastened the development of temporary disability insurance was by drawing attention to the gap in unemployment compensation protec-

[9] Considerable latitude was allowed the states in their legislation. The federal standards were minima.

[10] B. E. Wyatt, W. H. Wandel, and W. L. Schurtz, *The Social Security Act in Operation* (Washington, D.C.: Graphic Arts Press, 1937), p. 187.

[11] Other states which at some time had taxed employees are Indiana, Kentucky, Louisiana, Massachusetts, and New Hampshire.

[12] Of this $315,000,000, the California legislature authorized $103,000,000, the employees' tax for 1944 and 1945, to finance temporary disability insurance benefits.

tion during disability. Unemployment compensation plans have generally refused benefits to a person who, even though willing to work, was unable to do so because of a temporary disability.[13] Such a provision was intended to assure that an applicant for unemployment benefits was currently in the labor market. It raised the problem, however, of the worker without benefits when his needs are greatest—i.e., when hospitalization and medical-care costs are incurred while income has been stopped due to unemployment.[14]

INFLUENCE OF VOLUNTARY DISABILITY INSURANCE

Another factor exerting considerable influence on the development of compulsory disability insurance has been the widespread provision of sick benefit and wage-continuation plans by private industry. It has been said that "any impulse in the United States toward economic security makes its first appearance in private industry and business."[15] Private industry has been active, as we have seen, in promoting disability insurance. Many progressive employers, realizing the need for this protection for the workers, have provided it voluntarily. In other instances employees have taken the initiative and organized sick-benefit plans of their own. As the value of these provisions was demonstrated, there arose a demand for the extension of these benefits. Many believed that legislation was necessary in order to achieve this aim.

STATE LEGISLATION

Rhode Island

Rhode Island was the first state to adopt a compulsory disability program. The first bill was submitted to the legislature in

[13] A few states (Idaho, Maryland, Montana, Nevada, Tennessee, and Vermont) have passed what are called "Maryland Bills." These are amendments to state unemployment compensation laws which permit paying unemployment compensation benefits to workers who are disabled while unemployed.

[14] See also "Disability Benefits for Unemployed Workers," Chapter 8.

[15] Nathan Sinai, *Disability Compensation* (Ann Arbor: School of Public Health, University of Michigan, 1949), p. 10.

1942, and was passed during that session. In fact, only a brief ten-day period elapsed between the first favorable action of the Senate, passage by the House, and the signature of the Governor. This is not to say that consideration had not been given such legislation by interested parties prior to the above incidents, but no formal proposals had been made to the legislature prior to 1942.

The Rhode Island law provided for a monopolistic state fund supported solely by employee contributions. It provided that two thirds of the employee's current contribution toward unemployment should be diverted for this purpose. Benefits were restricted to weekly cash payments for lost time. The disability insurance program was completely co-ordinated with the unemployment compensation program. It was to be administered by the same agency and provided coverage for the same employees.

Certain provisions of the bill explain the lack of opposition and the resulting speed of passage. Since there were no medical-care provisions in the law, the medical profession did not oppose it. Employer groups offered no opposition—perhaps because no contribution on their part was called for. Employees were not asked to make any additional contributions and could foresee a new benefit. Difficult to understand, however, was the complete lack of interest, not to say lack of opposition, of the insurance industry. Various explanations have been offered for this apathy. Some have attributed it to neglect on the part of the industry's legislative representatives. The industry may have believed the legislation had no chance of passage and so gave it little consideration, or it may have believed that this legislation would serve as a stimulus to greater demand for commercial disability insurance.

The pioneering work in Rhode Island was difficult and there were few guides to follow. The speed with which the legislation was drawn suggests further that perhaps the best use was not made of data and experience available. Consequently, some fundamental changes have since been made, and they will be discussed in a later chapter. Rhode Island's early experience, though difficult, provides valuable guideposts for designers of legislation in other states.

California

The history of compulsory disability legislation in California followed a markedly different path from that in Rhode Island. Proposals had been presented to the legislature in 1941, 1943, 1945, and 1946. In 1942 and 1944 special studies were made by legislative committees.

Most of the pressure for legislation was exerted by organized labor. Labor was encouraged in its demands by the legislative and executive branches of the state government, which had been liberal in their approaches to social legislation. A temporary disability insurance bill that went before the legislature in 1945, was defeated by a very close vote. In 1946, a special session of the legislature was called for the purpose of considering disability legislation among other things. This intent was expressed in the Governor's opening message to the joint session of the Assembly and the Senate, and in more detail a few weeks later in a special message on disability insurance. In the latter message the need for such legislation was justified "because a person stands in even greater need of help when unemployed by reason of illness or disability than when he is well, but unemployed for economic reasons."[16]

Considerable interest was evidenced in the 1946 bill. The original bill was in many ways similar to the plan in operation in Rhode Island. It provided for a monopolistic state fund. Organized labor (state organizations of both AF of L and CIO), with the support of the Governor, was the primary proponent of the bill; employer groups and insurance companies made up the bulk of the opposition.

The original strategy of the opposition was to prevent passage of any bill proposing compulsory disability insurance. But as deliberations on the bill proceeded before the legislative committee, its imminent passage became apparent. In a last minute endeavor to prevent passage of this bill, which would exclude private insurance carriers, the opposition submitted a compromise amend-

[16] Message of Governor Earl Warren to the 56th Session of the State Legislature (January 23, 1946).

ment. The compromise accepted the principle of compulsion but permitted private insurance carriers to compete with the proposed state fund. The compromise bill was submitted and passed with relative ease. The CIO opposed the compromise bill on the grounds that only a monopolistic state fund was acceptable. In California, however, the AF of L was much the stronger organization and its support assured passage of the bill.

The bill, signed in March, 1946, provided that premium collections would start May, 1946, with benefit payments to start May, 1947. It also provided that should federal legislation authorize use of employee unemployment compensation contributions for state disability benefits, such benefits should commence ninety days after those funds became available. The Knowland Bill, subsequently passed by Congress, released additional funds contributed by employees for unemployment compensation and thus benefit payments in California started December 1, 1946.

As in Rhode Island, the California disability plan took the form of an amendment to the unemployment compensation law; but, unlike Rhode Island, private insurance carriers are permitted to compete with the California state fund. Coverage by the state disability insurance fund is automatic unless a private plan is submitted for approval.

Thus another stage was reached in the development of temporary disability insurance. The California pattern, which included private enterprise, was more acceptable to many followers of the movement. This fact, combined with the relative importance of the state of California, was stimulating to the further development of temporary disability insurance in the United States.

New Jersey

A commission on Postwar Economic Welfare was appointed in New Jersey in 1943, to study, among other things, a program to protect workers against the hazard of wage loss caused by illness or nonoccupational accidents. In April, 1946, a report on Cash Sickness Benefits was presented to the legislature, recommending a compulsory plan to be publicly supervised but privately

insured. The Commission presented several reasons to support this recommendation: the dual system adopted in California presented difficult administrative problems; the monopolistic state fund in Rhode Island had produced "decidedly unsatisfactory" results;[17] "government should not intervene in the employment relationship unless the need and conditions are beyond the capacity of private enterprise."[18] The recommendations were vigorously opposed by organized labor, which favored a monopolistic state fund, and also by employer groups, which proposed voluntary action through collective bargaining. Consequently no legislation was passed in 1946.

At the suggestion of the Governor, the Commission made revised recommendations to a special session of the legislature in 1947. The most important factors influencing the decision to submit a different proposal were: strong opposition within organized labor against an all-private insurance plan; lack of support of the 1946 plan by employer groups; Congressional legislation permitting the use of past employee contributions to unemployment compensation funds for state temporary disability benefits; and the successful operation of the California program for more than a year. The Commission proposed enactment of a California-type law. Appropriate bills were submitted to the legislature, but again no action was taken.

When the legislature convened the following year the issues had been reduced to a choice between a publicly supervised, privately insured plan and the California-type plan. Compromises had meantime been worked out by the major interested groups; employer groups now supported the former plan and labor supported the latter. On June 1, 1948, the legislature passed the California-type law, authorizing a state fund and competing private carriers, with benefits to become payable on January 1, 1949.

The New Jersey law differed in one important respect from the California law in that it provided for contributions by the employer, to be subject to experience rating.

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[17] Fourth Report of the State Commission on Post-War Economic Welfare, *Cash Sickness Benefits* (Trenton, N.J., 1946), p. 11.

[18] *Ibid.*, p. viii.

New York

New York has had a relatively long history of legislative interest in compulsory disability insurance. Proposals providing for cash sickness benefits for employees were considered as early as 1913. A commission appointed during World War I studied the state's health facilities and needs, and recommended a program of compulsory health insurance. A comprehensive medical-care and cash sickness benefits bill was submitted in 1920, but failed to pass. The issue lay dormant for more than a decade, to be revived in the late 1930's.

In 1944, the New York State Joint Legislative Committee on Industrial and Labor Conditions was appointed to undertake the study of proposals for a temporary disability insurance program. After much deliberation, and several unsuccessful proposals, a plan was suggested which would permit private insurance carriers to compete with a state fund in providing compulsory disability insurance. It was embodied in what became known as the Mailler-Condon Bill, submitted to the legislature in 1949. This bill, however, had the support of the State Federation of Labor and many employer groups. The State Federation of Labor was not completely satisfied, but supported the proposed bill in the belief that it was better than nothing. They also believed that amendments of their choosing could be made later. Most employer groups preferred no compulsory disability insurance whatever, but supported this bill which they could help fashion, rather than to oppose all plans and later have a less satisfactory bill receive sufficient support for passage. Support by employers was not unanimous, however, since some objected to the provision for employer contributions. The CIO, on the other hand, opposed it because the employers did not pay all costs.[19] Having sufficient support for passage the bill became effective April 13, 1949, benefits to be payable beginning July 1, 1950.

There are several fundamental differences between the New York plan and the plans in other states. Probably the most drastic

[19] Robert Tilove, "The New York Disability Benefits System," *Industrial and Labor Relations Review*, April, 1951, p. 417.

contrast is the co-ordination of the disability program with workmen's compensation rather than with unemployment compensation. It is reported that this arrangement stemmed from a decision by Governor Dewey, who recommended that the new disability plan, for reasons of economy be administered by an existing organization. The ability of the incumbent administrator was the deciding factor as to selection of organization. The choice made was the Workmen's Compensation Board because of the outstanding work of the chairman, Mary Donlon. Another report was that administration of the disability program was given by Governor Dewey to the chairman of the Workmen's Compensation Board as a reward for faithful support during the previous presidential campaign.

While there may be some truth to these stories, there were more fundamental reasons to support the decision. That there had been no employees' contribution to unemployment compensation in New York was a major factor. Proponents of the New York Disability Benefits Law have contended that administration of the disability program by the workmen's compensation agency is desirable since this agency has had experience in dealing with a parallel disability hazard. The nonoccupational disability hazard is more analagous to the occupational disability hazard, they have said, than it is to the unemployment hazard. The assured support of employer groups and the insurance industry was reportedly a factor in the choice of administrative agency. This support, in fact, has been achieved. Employer groups and the insurance industry have hailed the New York Law as legislation most appropriate to American conditions since it gives maximum scope to private industry.[20]

Other differences between the New York plan and the other plans are: the employer must make a positive choice between the State Insurance Fund, self-insurance, or a private insurance carrier in order to obtain the required insurance; the State Insurance Fund charges a manual premium varying with the risk; and a substantial portion of satutory benefits may be provided by benefits other than cash.

[20] *Ibid.*, pp. 415–38.

Other States

Many other states have introduced bills regarding temporary disability insurance in recent years. Only one other state, however, has passed such a bill. A law similar to the California law was passed in Washington in 1949, but the opposition was successful in submitting it to a referendum in which it was defeated by a wide margin. Opponents of compulsory disability insurance have pointed to results of the Washington referendum as a true expression of public opinion and have said that laws passed in other states were the result of pressure by minority groups and not of public demand. There is evidence, however, that the voters in the Washington referendum were not well informed on the issues.[21] Consequently, the results are probably not a reliable indication of the public's attitude.

Most state legislatures meet biennially. Save for budget sessions in even years, and emergency matters calling for special sessions, most states convene in the odd years. For that reason legislative action in the compulsory disability field has been most pronounced in 1949, 1951, 1953, and 1955. In some years, as many as forty-one compulsory temporary disability insurance bills have been introduced into sixteen states not having such laws. In other years new legislation has been considered by as few as two states. The past eight years have reflected a decreased legislative interest in the subject. While there were only half as many such bills submitted in 1955 as in 1949, there were, nevertheless, nineteen bills introduced into eleven states in 1955. In 1956 only two states considered disability insurance legislation. A rather surprising development took place in Congress recently. A bill for the District of Columbia, drafted by the U.S. Department of Labor (which has usually favored integration of disability insurance

[21] The opposition, comprised primarily of insurance companies and employer groups, was well financed. They used many billboards, newspaper ads, and premium notice enclosures emphasizing the additional wage deduction which passage of the bill would entail. In addition, it is reported that important labor groups, which did not oppose the bill in committee, opposed it during the referendum for political reasons. On the other hand, the Washington State Federation of Labor, the supporter of the bill, was reportedly handicapped in its campaigning by inadequate financing.

with unemployment compensation), "patterned somewhat after the New York law," was introduced in 1955, and again in 1956. It did not pass, however.[22]

There is a relative increase in the number of bills at the state level co-ordinating temporary disability insurance with workmen's compensation, and also a relative decrease in the number of proposals requiring a monopolistic state fund. In the past few years the most sustained interest has been shown in Arizona, Connecticut, Illinois, Massachusetts, Michigan, Minnesota, Ohio, and Pennsylvania. The probable trends of future legislative activity will be discussed later.

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[22] *Report of Committee on Compulsory Non-Occupational Disability Benefits Laws*, Insurance Section, American Bar Association, July 18, 1956.

PART · III

Characteristics of Present Plans

CHAPTER • 5

Characteristics of Plans Co-ordinated with Unemployment Compensation

DISABILITY insurance plans in California, New Jersey, Rhode Island, and the federal plan for railroad employees are co-ordinated with unemployment compensation. These disability plans are administered by the agency administering the parallel unemployment compensation programs, and many provisions of the latter are incorporated into the disability plans. This chapter and the next are limited to a description of the present laws. The development of these laws and an analysis of them will follow. Detailed description is not attempted. Furthermore, emphasis is placed upon characteristics common to more than one plan. Description and analysis throughout the study will be in terms of coverage, benefits, financing, and administration.

COVERAGE

Coverage refers to those employees who have potential benefit rights in a system of insurance. Coverage is not synonymous with eligibility for benefits. In insurance it is possible to pay premiums and yet not receive benefits, and it is also possible to receive benefits without having paid premiums. Coverage refers to tax status, not benefit status.

In each of the plans mentioned above, coverage for disability insurance is the same as that for unemployment compensation, with which it is co-ordinated. Coverage among state plans, however, is not identical. Indeed, there is considerable variation

among the unemployment compensation laws, and thus among the temporary disability insurance laws of the several states.

New Jersey covers all employees who work for firms employing four or more individuals for some portion of a day in each of twenty weeks in a calendar year. California differs in that all employees of each firm whose payroll exceeds $100 in a calendar quarter are covered, regardless of the number of employees. Rhode Island covers employees of all firms without reference to earnings. All three plans exclude agricultural labor; family employment; domestic service; service performed for national, state,[1] or local governments; railroad employment; and employment by nonprofit institutions. In each of these three states it is possible for workers to elect to remain out of the program on religious grounds.

The railroad plan applies to all carriers and their associations, their owned or controlled affiliates, express and sleeping car companies, traffic associations, and standard railroad unions and their various agencies. In broad terms, it covers the entire railroad transportation industry.

The total number of employees covered under these four plans at the end of 1955 was in excess of six million: approximately 250,000 in Rhode Island; 1,450,000 in New Jersey; 3,150,000 in California; and 1,400,000 in the railroad plan.

BENEFITS

Qualifying Conditions

Definition of Disability. Compensable disability is usually defined as disability which results from any accident or sickness not compensable under the workmen's compensation law and which results in total inability to perform regular or customary work. New Jersey has a further qualification that if the worker is unemployed at the time the disability occurs he must be unable to perform any work for pay. New Jersey does not pay benefits for

[1] Effective January 1, 1956, Rhode Island extended coverage under both unemployment insurance and temporary disability insurance to employees of the State of Rhode Island.

disability arising from pregnancy, nor are benefits for pregnancy payable in California unless the disability lasts more than twenty-eight days following termination of pregnancy. Rhode Island, however, pays a maximum of twelve weeks of benefits for pregnancy, beginning six weeks prior to expected childbirth. The railroad plan pays maternity benefits for a period of 115 days, beginning 57 days before expected childbirth. In both plans pregnancy benefits apply only to covered workers—not dependents.

Eligibility Requirements. There are eligibility requirements which a covered worker must satisfy, even though he is disabled as defined by law. In California he must have earned in the base period (first four of the last five quarters preceding commencement of any period of disability) $750, or, if less than $750, thirty times the weekly benefit amount.[2] Rhode Island requires only that he must have earned thirty times the weekly benefit amount. In New Jersey he must have earned at least $15 in each of seventeen weeks within the fifty-two weeks preceding commencement of disability. In the railroad plan he must have earned $400 in the base period.

Waiting Period. In each plan there is a seven-day waiting period between the first day of disability and the first day benefits are due. California and New Jersey require a waiting period for each disability claim, but Rhode Island and the railroad plan require only one waiting period for each benefit year. California also grants supplementary hospital benefits for which there is no waiting period if the individual is hospitalized for a day or more, in which case any unexpired portion of the waiting period is waived.

Disqualifications. In most plans a claimant is disqualified for knowingly making false or fraudulent statements, or not being under the care of a physician. In California and New Jersey a claimant is also disqualified for disability benefits if he is ineligible for unemployment compensation because of a labor dispute. California recently qualified the above rule by adding, "un-

[2] The "weekly benefit amount" is the rate of benefit received weekly. In California the rate is determined from a table using quarterly earnings; a rate two thirds of the average weekly wage is used in New Jersey. These formulae usually grant a benefit varying from one half to two thirds of average wages.

less he established to the satisfaction of the director that he is suffering a bona fide illness or injury and the director finds that there is good cause for paying disability benefits."

New Jersey prohibits receipt of temporary disability insurance benefits for any period with respect to which workmen's compensation (other than benefits for a permanent disability previously incurred) is paid or is payable. The railroad plan makes it impossible for an employee to receive both disability benefits and wages concurrently.

Amount and Duration of Benefits

Amount of Benefits. Rhode Island and California determine their benefit amounts by the amount earned in the base year quarter in which earnings are the highest; e.g., claimants having earned between $450–$474 in that period receive $23 per week.[3] In New Jersey benefits now represent two thirds of the average weekly wage during the eight weeks of covered employment immediately preceding the calendar week in which disability commenced. The railroad plan has a benefit table which bases the daily benefit rate upon total wages earned in the base year. All of the plans have minimum and maximum benefit rates which run from a minimum of $10 to a maximum of $25 to $37.50 per week. Proportionate benefits are paid also for partial weeks of disability.

Partial Benefits. Partial benefits in the usual sense—to pay for partial disability—are not paid in temporary disability insurance. In another sense, benefits less than the full weekly benefit amount are granted in some plans to claimants also receiving workmen's compensation or wages. In Rhode Island, it is possible for a claimant to receive combined workmen's compensation and temporary disability benefits up to 85 per cent of the average weekly wage on the last job prior to disablement. The California plan and the railroad plan specify that the claimant cannot receive temporary disability and workmen's compensation benefits for the same disability, unless workmen's compensation is less

[3] See "Benefit Formula," Chapter 8 for an explanation of terms and the logic behind this method of determining benefit amounts.

than the disability benefits, in which case the difference is payable.

Disability insurance claimants in New Jersey may receive such benefits in conjunction with wages if the two combined do not exceed regular weekly wages. California permits an employee to receive benefits and wages concurrently if the two combined do not exceed 70 per cent of wages prior to disability.

Both New Jersey and the railroad plan reduce benefits by the amount of pensions (excluding employer-paid railroad pensions) received.

Supplementary Benefits. Supplementary benefits of $10 a day are granted in California to a disabled individual, eligible for weekly benefits, who is confined in a hospital on his doctor's orders. These benefits are limited to twelve days for each disability. When a claimant is hospitalized for a day or more, any unexpired portion of the waiting period is waived for the receipt of weekly benefits. As stated above, Rhode Island and the railroad plan grant benefits for pregnancy.

Duration of Benefits. Each of these plans has a maximum duration of benefits of twenty-six weeks. In some cases the maximum is twenty-six weeks or one half of base-period wages (whichever is the lesser), or some similar limitation.

FINANCIAL PROVISIONS

Source of Funds

The Rhode Island and California state funds are financed by a payroll tax on employees only. The New Jersey state fund is financed by a payroll tax on both employees and employers. As stated in Chapter 4, each of these state funds can also use employees' past contributions to unemployment insurance. However, such contributions may be used only to pay benefits. Disability benefits for the railroad plan are paid out of the railroad unemployment insurance fund, which is financed by a payroll tax paid by employers.

Private plans[4] in California and New Jersey may be financed

[4] "Private plans" is frequently used to refer to privately insured plans.

from the same sources as are the state funds. Many plans, however, are financed exclusively by employers as part of the employee-welfare program.

Benefits to disabled unemployed workers are financed separately from regular benefits in California and New Jersey. In both states a separate account for the disabled unemployed is established in the state fund from which benefits are paid. This account is credited with interest earned on employee contributions withdrawn from the unemployment trust fund.[5] In the event of a deficit in the disabled-unemployed account, voluntary-plan employers may be taxed a proportionate share of the deficit. These assessments are limited to 0.03 and 0.02 per cent of taxable wages in California and New Jersey respectively.

Contribution Rate

Employees in California finance their disability state fund by a 1 per cent tax on all payrolls up to $3,000 per calendar year. Rhode Island workers pay the same percentage of the first $3,600 of wages.

Employees covered by the New Jersey state fund pay 0.5 per cent of wages, up to $3,000. Employers covered by that state fund pay 0.25 per cent of their taxable payroll. The employers' contributions are modified by experience rating. They receive credits or penalties, by way of a reduced or increased contribution rate, depending upon the rate of disability experienced by their employees.[6]

One contribution by railroad employers finances both disability insurance and unemployment compensation. The rate of contribution varies according to the balance in this joint fund on September 30, of the preceding year, and can range from 0.5 per cent to 3.0 per cent of the annual payroll up to $3,600. The balance has been so large that the low rate of 0.5 per cent has prevailed for the past few years, and is expected to be maintained for some years to come.

Private plans in California and New Jersey may be financed

[5] See "Disability Benefits for Unemployed Workers," Chapter 8.
[6] See "State Merit Rating Provisions," Chapter 9.

as desired, provided that the employee is not made to contribute more than he would have contributed to the state fund. Employers with private plans are assessed by the state for the added administrative costs attributable to them,[7] and for benefits to unemployed disability claimants. These assessments are variable, subject to maximum percentages of payroll.

ADMINISTRATION

Administrative Agency

Each of the above plans is administered by the same agency that administers unemployment compensation. The integration of the two systems is closest in the railroad plan. Here the disability benefits are provided by an amendment to the Railroad Unemployment Insurance Act, which is administered by the Railroad Retirement Board. There is a common fund for disability insurance and unemployment compensation, and as far as possible the provisions of the two plans are identical. In effect, for purposes of compensation, disability is considered to be unemployment.

A division of the Department of Employment Security administers disability insurance in Rhode Island. The California disability insurance program is administered by the Department of Employment, whose broad policy is determined by an Employment Stabilization Commission of five members. The administration of the Temporary Disability Benefits Law in New Jersey is the responsibility of the Division of Employment Security under the Department of Labor and Industry.

General Administration

The Temporary Disability Insurance Division, one of five divisions of the Rhode Island Department of Employment Security, processes disability claims and pays benefits. In addition, services are performed for the disability insurance program in the fiscal affairs, legal affairs, and standards and planning divisions. An Advisory Council reviews operating procedures of the Depart-

[7] See "Administrative Costs," Chapter 10.

ment and proposes changes to the Governor. There is also a Board of Review to serve as final authority in all unemployment and disability claims disputes. The administration is completely centralized.

The Division of Disability and Hospital Benefits in California functions on a decentralized basis with a division chief and assistant, three area supervisors, and sixteen district managers. Each district manager is in charge of a district office, which is separate from the unemployment compensation office. However, the disability program utilizes many services of the unemployment compensation division, such as statistical, personnel, and wage record facilities. There is also an educational unit which informs employees and employers of their rights and obligations under the program.

The administration of disability insurance is highly centralized in the New Jersey plan. Field investigators are the only personnel who do not have their offices in Trenton. Headed by a Superintendent, the program operates as the Disability Insurance Service within the Division of Employment Security. Within the Service are two bureaus; one administers the state plan, the other supervises private plans.

The administration of the railroad plan is a part of the unemployment insurance system and no separate agency or division has been set up.

Administrative Costs

Rhode Island permits 6 per cent of contributions to be used for administrative purposes. California has no limit based on contributions, but receives a lump sum determined annually by the State Director of Finance. New Jersey[8] provides for administrative costs by allowing 0.08 per cent of taxable wages, plus an assessment on employers in the state plan, for costs of maintaining separate accounts for experience-rating purposes. The railroad plan allows 0.2 per cent of taxable wages to be used for the administration of both the unemployment and the disability insurance programs. There are no special provisions for the latter.

[8] See "Administrative Costs," Chapter 10, for experience data in these states.

Claim Procedure

The state plans require the disabled employee to submit, by mail, to the disability agency, a claim form giving identifying and wage information. In addition, the attending physician supplies a medical form containing information pertaining to the diagnosis and probable duration of disability. The agency verifies the fact that the doctor is qualified to certify claims, and also compares the estimate of duration with the diagnosis. This form provides the basis for estimated duration of benefits. Wage records of the claimant are then reviewed to further determine eligibility and weekly benefit amount. If everything is in order a claim card is punched, forwarded to the check-writing unit, and the benefit check is mailed.[9]

The weekly benefit check is accompanied by a continued claim form. This form, which must be returned weekly to the agency, records the fact of continued disability (no medical evidence required) or the last day of disability. If the claimant is disabled as long as estimated, the check for the last week of disability is accompanied by a notice that his disability should have ended and that this is, therefore, his last check. If he is still unable to work because of disability he must submit a written statement from his doctor to justify extension of his claim.

The claimant's employer is sent notice of the first claim, which he is requested to complete and return. There is space for reporting when and why the claimant stopped work, whether he is covered by a private plan, has returned to work, is receiving regular wages or vacation pay, with the dates and amount of such pay. There is also a question concerning any reasons for believing that the claimant is not eligible for state disability benefits. An employer who returns the notice receives a copy of the determination of eligibility or ineligibility.

Cases arise where the acceptance or continuation of a claim does not appear to be justified. In such cases the claimant may receive a letter directing him to have, at the agency's expense, a

[9] See Appendix for sample claim forms.

medical examination by a specified physician.[10] The claimant is reminded of the stipulation that in order to receive disability benefits he must "submit to a reasonable examination as required." The designated physician receives, with additional information, a copy of the letter to the patient. This physician may be any licensed member of the profession—other than the one who is treating the patient. Another source of information for checking on claimants is the unscheduled visit. Field investigators may make unscheduled calls on claimants in order to verify evidence of disability.[11]

In all these plans there is a time limit, varying from nine to thirty days after the beginning of the disability, within which the claimant must file in order to receive all benefits to which he would otherwise be entitled. In New Jersey and Rhode Island all claims are processed by the central office. Claim administration is decentralized in California and in the railroad plan.

All plans provide an opportunity for claimants to appeal decisions of the administrative agency. Usually opportunity for hearings before a special examiner or referee is provided, from which appeals may be carried to an appeal board.

Medical Administration

Medical administrative procedures in Rhode Island and in the railroad plan are sufficiently similar to those in California to justify limiting discussion to the latter. Medical services are supervised by a medical director, located in Sacramento, and two assistants, one located in San Francisco and one in Los Angeles. The medical director is responsible to the Director of the Department of Employment, and is independent of the Division of Disability and Hospital Benefits. His duties are to supervise the review of claims, train lay claims examiners, review appeals decisions, and promote co-operation with the medical profession. No physical examinations are conducted by agency physicians.

All first claims are certified by a physician, surgeon, chiropractor, osteopath, dentist, chiropodist, or a religious practitioner en-

[10] See "Medical Administration," Chapter 10.

[11] See p. 201.

gaged by the claimant. These certifications are reviewed by the agency. Most continued claims do not require further certification. Occasionally an additional certificate may be required in prolonged cases. Questionable prognoses, and disabilities continuing longer than estimated, are often checked by an "independent medical examiner." The act provides that claimants must submit "to a reasonable examination or examinations if so required by the Commission for the purpose of . . . determining . . . disability." These examinations are made by a licensed doctor selected from those who have expressed a desire to perform examinations and whose reports have been adequate and impartial. The agency pays the doctor for such examinations. These examinations aid in the determination of eligibility for benefits.

Medical administration in New Jersey is provided by the State Health Department. Procedures are similar to those followed in California. Medical examiners, however, are designated by county medical societies.

Private Plans

No provisions are made in the Rhode Island plan or the railroad plan for the private insurance of the disability hazard.

California and New Jersey provide that any employer subject to the law may submit private insurance in lieu of state insurance. Private insurance may be self-insured or with an admitted commercial insurance carrier. If self-insurance is submitted the employer must put up bond or other security. All private insurance must be approved by the supervising agency.

New Jersey requires that private plans must offer protection at least equal to that provided by the state. California requires that private plan benefits must be more liberal than the state plan. This is usually interpreted to mean that benefits more liberal in at least one respect must be provided, e.g., a shorter waiting period, or larger weekly benefits.

In both California and New Jersey the approval of a majority of the employees must be secured before contracting out, i.e., coverage provided by other than the state plan, will be approved. In

no case will a plan be approved if the employee's contributions are to be more than they would be if the state were the insurer.

As stated before, private plans are assessed administrative costs attributable to them. The assessment is prorated among these plans on the basis of wages paid to the individuals covered. The amount of the assessment in both states is limited to 0.02 per cent of such wages.

CHAPTER • 6

Characteristics of the New York Plan

THE New York Disability Benefits Law (hereafter referred to as DBL) differs from previous legislation in several respects. The major difference is that the New York statute is an employer's liability type of law—the first disability insurance law of this type. The law makes it an obligation of the employer to elect positively an insurer; there is a state fund but failure to elect does not result in automatic state-fund coverage. The employer may insure or self-insure. If the decision is to insure, the required coverage may be obtained from a commercial carrier or from the State Insurance Fund.

The New York State Insurance Fund differs from the usual state disability fund in that it charges a variable premium, depending upon the risk assumed. It differs from commercial carriers in that it is operated by the state and must accept all who apply for coverage, but this is relatively unimportant, since approximately 97 per cent of insured workers are covered by self-insured or commercially insured plans.[1] The program is therefore very close to being an all-private one.

DBL further differs from other disability plans in the benefits required, method of financing, and in the administration, which will be discussed more fully under the appropriate headings.

COVERAGE

DBL is generally co-ordinated with workmen's compensation, but coverage provisions more closely resemble those of unemploy-

[1] New York Workmen's Compensation Board, *1955 Annual Report*, p. 18. Data supplied by the New York State Insurance Fund.

ment compensation. All employees are covered for disability benefits who work for employers of four or more persons on each of at least thirty different days in a calendar year. The employer continues to be a covered employer until the end of any calendar year in which he has not had four or more employees on each of at least thirty days.

DBL does not apply to: the spouse or minor child of the employer; employees performing services for the state,[2] municipal governments, or religious, charitable, and educational nonprofit organizations (employees of nonprofit corporations who are engaged in commercial enterprises are covered); railroad employees; members of the merchant marine; farm laborers or casual employees.

An employee who belongs to a religious group which depends upon prayer or spiritual means for healing may elect out of, and thereby waive benefits under, the law by filing a statement with the proper authorities. Thereafter such an employee is exempt from any liability to contribute toward the cost of such benefits, and his employer is relieved of responsibility to provide for the payment of benefits to such employee under the law. Such an employee, however, is counted as an employee in determining whether an employer is a covered employer.

There were approximately 4,725,000 employees covered by DBL at the end of 1955.[3]

BENEFITS

Qualifying Conditions

Definition of Disability. Both employed and unemployed workers can qualify for disability benefits in New York, but the definition of disability is not the same in both cases.

For the employed worker disability is the inability, because of injury or sickness not arising out of and in the course of employ-

[2] Although New York State employees are covered by the unemployment insurance law, they are not covered by DBL.

[3] New York Workmen's Compensation Board, *op. cit.*, p. 18.

ment, to perform regular duties of his occupation or any other work his employer offers him at his regular wages.

For the unemployed worker disability is the inability, because of injury or sickness not arising out of and in the course of employment, to perform duties of any employment for which he is reasonably qualified by training and experience.

No payments are made for any period of disability caused by or arising in connection with pregnancy, unless it occurs after return to covered employment for at least two consecutive weeks following termination of pregnancy.

Nor are payments made for any period of disability due to the willful intention of an employee to bring about injury or illness to himself or another, or due to injury sustained in the committing of an illegal act. There is a further exclusion that no payments are made for a disability which results from an act of war occurring after June 30, 1950.

Eligibility Requirements. Because DBL is based on workmen's compensation rather than on unemployment insurance, it has different employment eligibility requirements for the employed and the unemployed.

The employed worker, to be eligible, must have been employed four or more consecutive weeks in covered employment, or twenty-five days in regular part-time employment, prior to the commencement of the disability for which claim is filed. If the worker is qualified as defined above and is subsequently unemployed for less than four weeks, he is eligible immediately upon employment with a covered employer.

If a worker has qualified for disability benefits he can continue to qualify for benefits during a period of four weeks after termination of such employment, but not beyond the fifth day on which he again performs work for remuneration or profit. The disability insurance requirements for the worker who has been out of covered employment more than four weeks are complicated. For all practical purposes, to receive disability benefits, he must have been receiving unemployment insurance benefits immediately prior to the commencement of disability.

Waiting Period. The first seven days of disability constitute

a waiting period during which no benefits are paid. Successive disabilities caused by the same (or related) injury or sickness, are considered a single period of disability requiring only one waiting period if separated by less than three months. If the claimant for disability benefits has been receiving unemployment insurance benefits, or is otherwise eligible to receive them, there is no waiting period for disability benefits other than the waiting period for unemployment insurance.

Disqualifications. A claimant is disqualified under DBL if he is or would be subject to suspension or disqualification under the unemployment insurance law. A claimant is further disqualified if he is not under the care of an "authorized" physician, if he is performing work for remuneration or profit, or if the disability commenced prior to the time the employee became eligible under this law.

No benefits are payable under this law if the claimant is receiving benefits under any unemployment insurance law or under any workmen's compensation act.

Amount and Duration of Benefits

Amount of Benefits. The weekly benefit to which the disabled employee is entitled is one half of the employee's average weekly wage. This sum is subject to a maximum of $40, and a minimum of $10, unless the average weekly wage is less than $10, in which case the benefit is the average weekly wage.

The average weekly wage is determined by dividing the wages paid by the last employer for the eight weeks immediately preceding the disability by the number of weeks worked during that period. Adjustments are possible if this sum does not represent a fair approximation of normal earnings, or if the employee did not work for his last covered employer during this eight-week period.

Partial Benefits. When the period of disability for which the claimant is eligible for benefits is less than a full week, the benefits payable are calculated by dividing the weekly benefit by the number of the employee's normal work days per week and multiplying the quotient by the number of normal work days in such period of disability. When a claimant is eligible for benefits from

more than one covered employer, his benefits are one half the total of the average weekly wages received from all such covered employers, subject to the minimum and maximum amounts, and are allocated in the proportion of their respective average weekly wage payments.

Supplementary Benefits. An unusual feature of the New York Law is that regulations have been issued which permit the benefit requirement to be fulfilled in part by hospitalization and surgical benefits in kind, as well as by cash.[4] The present regulation is that cash payments must have a value at least equal to 60 per cent of total disability benefits due the claimant.

Duration of Benefits. The duration of disability benefits is twenty weeks in any period of fifty-two consecutive calendar weeks, or during any single period of disability. If the disability claimant is unemployed, no benefits are payable beyond the twenty-sixth week of unemployment.

FINANCIAL PROVISIONS

Source of Funds

Benefits under DBL are financed by contributions from both the employer and the employee, collected by the employer through payroll deductions. If desired, the employer may pay the entire contribution.

There was no opportunity in New York to recover that portion of the unemployment tax for disability benefits paid by employees, for no portion of this tax had been paid by them. Since a new tax had to be imposed, "it was felt that joint contributions by employers and employees would, in any event, make for a sounder program, since then both employers and employees would have an interest and an obligation to see that it worked effectively."[5]

The employer is liable for disability benefits for four weeks after termination of employment. A Special Fund provides bene-

[4] See "Medical Benefits," Chapter 8.

[5] New York Joint Legislative Committee on Interstate Cooperation, *Interstate Conference on Non-Occupational Disability Benefits Programs* (1949), p. 19.

fits for the unemployed who become disabled after such period. This Fund, financed initially through temporary contributions of employers and employees during the period from January 1, 1950 to June 30, 1950, is maintained by penalties collected as provided in the law and by assessments levied against self-insurers, the State Insurance Fund, and commercial carriers. These assessments are levied only if the net assets of the Fund fall below a statutory limit, and then only as necessary to restore the Fund to the statutory level.[6]

Contribution Rate

The employee contributes 0.5 per cent of wages toward the cost of disability benefits, but not more than 30 cents a week, or $1.30 a month. The employer pays all cost not met by the contributions of his employees. At the inauguration of the program, the employer's costs were estimated to be about 30 cents a week for each worker, or about equal to the contributions of the employees.[7]

The cost of providing disability benefits varies from year to year, depending upon experience. Therefore, since the employee's contribution is constant and cannot exceed 30 cents a week, the employer contributes the balance necessary to cover costs.

ADMINISTRATION

Administrative Agency

The Disability Benefits Law is administered by the New York State Workmen's Compensation Board. The chairman of the Board is responsible directly to the Governor.

General Administration

Administration of DBL is not centralized in any one division of the Workmen's Compensation Board. There is rather close

[6] See "Disability Benefits for Unemployed Workers," Chapter 8.

[7] New York Joint Legislative Committee on Interstate Cooperation, *op. cit.*, p. 16. See also p. 137.

integration of temporary disability insurance administration with workmen's compensation. Very few Board employees work exclusively with temporary disability insurance; e.g., the "Plans Acceptance," "Claims," "Self-Insurance," and "Research and Statistics" units aid in administering both workmen's compensation and temporary disability insurance. All unit supervisors report directly to the Board chairman.

Administrative Costs

The disability benefits program is charged a share of all expenses incurred by the Workmen's Compensation Board. These costs are assessed against self-insurers, commercial insurance companies, and the State Insurance Fund in the proportion which the payrolls covered by such carriers bear to the total of all such payrolls for that calendar year.[8] These assessments are made as soon after April 1 as is practicable. Assessments for the first two years, however, were combined.

Claim Procedure

The claim procedure followed in most cases is determined by the individual carrier. A claim form authorized by the Workmen's Compensation Board, containing the claimant's and doctor's report, must be used. The usual procedure is for the claimant to obtain the form from his employer and fill in the information required of him. This same form is then given to the examining physician who fills in his portion of it, including the estimated return-to-work date. Then the employer usually attaches a report containing a record of earnings before forwarding the form to the carrier. The benefit amount is calculated from the information given and benefit checks are mailed biweekly. A week or two before the estimated recovery date, on prolonged disabilities, the carrier, with the help of the doctor or employer, checks on the claimant's status (this is done more frequently when deemed desirable). At the initiation of the claim, a return-to-work notice is sent the employer requesting that the carrier be notified immediately of the date the claimant reports back to work. Bene-

[8] See "Administrative Costs," Chapter 10, for a more detailed discussion.

fit payments are stopped upon receipt of such notice or on the date of estimated recovery, unless further proof of disability is presented.

The procedure for claims filed with the Special Fund by claimants unemployed in excess of four weeks, is similar to that followed in the state funds described in Chapter 5.

Medical Administration

A medical administrative unit, responsible to the Board chairman, is in charge of the medical administration of DBL. This unit has little to do with most claims, since only those filed with the Special Fund are reviewed by it.

All claims filed with the Special Fund must be certified by a physician approved by the Board.[9] These claims are reviewed by an agency physician. In the event questions arise as to medical certification, further information may be requested from the attending physician. Impartial examinations may be called for.

[9] Most licensed physicians who apply are approved.

PART · IV

Problem Analysis

CHAPTER • 7

Problems Pertaining to Coverage

SINCE no one is exempt from the possibility of being disabled, it would seem that all workers should receive protection against the risk of wage loss due to temporary disability. Yet the present statutes exempt from coverage large numbers of gainfully occupied persons. Most exemptions have been made for administrative reasons, some to avoid jeopardizing the tax status of the employers, and some for a variety of other reasons. Most of the questions raised as to coverage have had to do with the self-employed, employees of governmental units or nonprofit organizations, and those who work for small employers. Questions have also been raised concerning greater co-ordination of coverage under the disability program with that of the unemployment compensation program.

SELF-EMPLOYED

All state plans exclude the self-employed from coverage. The primary reason for exemption has been to simplify administrative procedures. The self-employed do not receive income from a payroll; consequently, unless a flat contribution were used, a statement of profits and losses would be required to determine the amount of their contribution. Moreover, the state's administrative costs would be relatively high because of the large number of small reporting units. The force of these arguments has been reduced, however, by the development of simplified administrative procedures, as well as the requirement that most self-employed individuals must file income tax returns.

Recent amendments to the Social Security Act have broadened OASI coverage to include many urban self-employed persons, and have provided a tax return geared to income tax schedules. Contributions are paid annually or quarterly, along with the income tax. It has been argued that the states could adopt a similar device for disability insurance. Having computed net income for federal tax purposes, the self-employed could easily adapt this information for use by the state disability program.

It is argued further that quarterly wage reports are used in unemployment compensation and temporary disability insurance. The weekly benefit amount in unemployment compensation and temporary disability insurance, in some cases, is calculated from total quarterly earnings. Consequently, information from Social Security reports filed by self-employed workers could be used by some disability insurance programs with little or no modification of the present systems. Other programs could very likely make necessary adaptations without great difficulty.

Nevertheless, some characteristics of the self-employed worker do raise questions as to whether he should be covered by temporary disability insurance. For instance, his temporary incapacity for work does not necessarily cause loss of income—an employee or relative may temporarily carry on the business or enterprise. It may often be difficult to determine the precise loss which he sustains because of temporary disability. It is possible for him to be incapacitated for a month or six weeks and still maintain his usual quarterly or annual earnings.

EXCLUDED EMPLOYEE GROUPS

Agricultural Workers

Agricultural workers are excluded from all temporary disability insurance plans. This stems from their exclusion by the respective unemployment compensation systems.[1] Administrative

[1] California, New Jersey, and Rhode Island have disability insurance coverage identical with that for unemployment compensation. In New York the two plans have similar, though not identical, coverage provisions.

problems have been given as one reason for excluding agricultural workers from unemployment compensation. Another reason is that the causes and nature of unemployment in agriculture are different from those in industry. An economic slump affects employment in agriculture differently from that in industry. During an economic slump, industry tends to maintain prices and reduce output, and consequently reduce employment. Conversely, agriculture, in such an event, is faced with declining prices, and reacts by maintaining, or even increasing, production, and consequently increasing employment.

But even if agricultural employment and unemployment be considered a special case, this does not morally justify the exclusion of agricultural workers from temporary disability insurance laws. In fact, the prevailing low wages in agricultural work emphasize the need for coverage.

Governmental Units and Nonprofit Organizations

The exclusion of governmental units and nonprofit organizations from the disability program[2] is a carry-over from the federal unemployment law, and thus from the state unemployment compensation laws.[3] The exemptions were written into the federal Social Security statute because of constitutional questions regarding federal taxation of state and municipal governments, and because of a long-established federal policy against taxing charitable institutions.[4] These reasons, however, are now purely historical. Furthermore, since temporary disability insurance is exclusively state legislation, it need not be hampered by restrictions imposed on other programs. Consequently, there seems to be no adequate reason for exempting governmental units or nonprofit organizations from temporary disability insurance.

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[2] See footnote 1, Chapter 5.

[3] The precedent for these exclusions was set earlier by Workmen's Compensation laws.

[4] Exemption of these organizations from taxation in general is based on the notion that they should be financially unhampered to devote all their funds to charitable, religious, and educational ends. While these goals are socially desirable, so is the provision of disability benefits for their workers.

RELIGIOUS EXEMPTIONS

Persons whose religious beliefs require them to depend for healing upon faith or prayer present something of a problem in equity in a disability insurance program. Many such individuals are unwilling to consult physicians; therefore, if certification of disability by a physician is required as a condition of eligibility, such individuals are not able to comply. This problem has been approached in two different ways. New Jersey, New York, and Rhode Island permit such an individual to present an affidavit indicating that he is a member of a sect which believes in healing by faith or prayer, and the individual is thereafter exempt from paying contributions and is ineligible to receive benefits under the law. California originally had no provision for exemption; amendments, however, now permit certification of disability by authorized practitioners of sects believing in faith healing. Since 1951, California has also had a provision permitting such persons to "elect out" of the law, which seems preferable to permitting certification by religious healers, provided there is evidence of such belief.

NUMBER OF EMPLOYEES

In two of the four states employees are not covered, regardless of their industrial classification, if they work for employers hiring only three persons or less. This provision, too, is a carry-over from state unemployment compensation provisions. The federal Social Security Act originally specified that only employers of eight or more were subject to the unemployment compensation tax, and most states followed this exclusion in their legislation. This provision, *inter alia*, was included to simplify administration.

Many states have now entirely eliminated this small-employer exemption from their unemployment compensation laws, and report satisfactory experience.[5] California, for example, has iden-

[5] "Insurance Against Temporary Disability: A Blueprint for State Action," *Yale Law Journal*, April, 1951, p. 653.

tical unemployment compensation and disability insurance coverage provisions, i.e., employees of employers of one or more workers. California has demonstrated that small employers can be effectively covered without excessive administrative difficulty. Administrative costs in this state compare very favorably with the states retaining the more restrictive provisions.[6] No insuperable problems of compliance have been reported as a consequence of this provision. Labor unions have pressed for the elimination of this small-employer exemption in both unemployment compensation laws and disability insurance laws. One cogent argument used to win support of employer groups has been that such an exemption in a law discriminates against the larger employers. Where an employer contribution to disability insurance is required, it is argued, this tax is ultimately reflected in price. Hence a small producer not required to contribute enjoys a price advantage.

CO-ORDINATION OF TEMPORARY DISABILITY INSURANCE COVERAGE WITH OTHER SOCIAL INSURANCES

California, New Jersey, Rhode Island, and the railroad plan have temporary disability insurance coverage provisions identical with those in their unemployment compensation programs. Identical coverage offers definite advantages to both programs, permitting joint use of wage and employment reports from the employer, agency wage records, employer liability determinations, records of subject employers, and field audits. Differences in coverage make administration more complex, and the potential economy of joint operation is reduced. Coverage differences would result in more employers' reporting errors, which would also contribute to administrative problems and costs. Employers also benefit from identical coverage by having fewer reports to file, and fewer coverage interpretations to maintain.

Still another advantage is offered both programs by joint cover-

[6] See "Administrative Costs," Chapter 10.

age. Whereas some employee groups, such as those employed by small firms, cannot be economically covered by one social insurance program, they may be if employee records were utilized by two such programs.

The New York plan, although administered by the Workmen's Compensation Board, has coverage similar to (but not identical with) that of unemployment compensation. It is contended that these differences, though small, lead to unnecessary administrative problems.[7] Such problems, however, are not inherent in co-ordination with workmen's compensation.

There are disadvantages, as well as advantages, in co-ordinating a disability insurance plan with either of the above programs. The disability plan will be subject to the limitations, as well as to the strengths of any plan with which it is co-ordinated.

It is unlikely, for example, that the coverage provisions in the unemployment or workmen's compensation programs should be precisely those desired for disability insurance; e.g., exclusion of agricultural workers from unemployment compensation.[8] It is questionable whether administrative economies justify the exclusion of large numbers of employees from temporary disability insurance merely because they are excluded from unemployment or workmen's compensation.

TRENDS

In all probability, coverage under the present programs will be broadened. Labor has consistently advocated such changes.[9] Insurance companies have gone on record as not opposing them.[10]

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[7] Herman A. Gray, "Cash Disability Benefits in the United States," *New York University, Second Annual Conference on Labor* (Albany: Matthew Bender Co., Inc., 1949), p. 320.

[8] See also "Supervisory-Administrative Agency," Chapter 10.

[9] Statement of Everett Friedman, International Ladies' Garment Workers' Union, before the Legislative Commission on New Jersey Unemployment Compensation and Temporary Disability Benefits Law, December 20, 1950.

Memorandum on Behalf of the International Ladies' Garment Workers' Union presented by Morris Glushein at the Public Hearings on New Proposed Regulations under the New York DBL, October 20, 1949 at Albany, N.Y.

[10] F. T. Curran, "Statutory Disability," paper given at the Educational Seminar on Group Accident and Health Insurance conducted by the Bureau of Accident and Health Underwriters, February 15, 1951.

New administrative techniques and mechanical record-keeping devices are demonstrating the feasibility of covering many groups that were formerly excluded. The history of similar programs in Europe has been that coverage has gradually been increased until nearly all workers are covered.

CHAPTER • 8

Problems Pertaining to Benefits

It has been said that Americans are "benefit-minded," rather than "insurance-minded"; i.e., most people are interested in what they can collect from an insurance program, to the exclusion of all other provisions. This may explain, in part, the fact that many problems have arisen in relation to benefits in the operation of temporary disability insurance programs. Labor, one of the most articulate groups concerned with this legislation, has taken an active interest in benefits. Employer groups and the insurance industry have also voiced their interest. Benefit problems are many; the most pressing relate to basic cash benefits, maternity benefits, and medical-care benefits. These and other problems, will be discussed in this chapter, along with the probable trends.

QUALIFICATION FOR BENEFITS

Few problems have arisen in relation to qualification for benefits, and while they have not been major problems, a discussion may aid in a better understanding of the problems that follow.

Eligibility Requirements

Since the purpose of disability insurance is to protect the worker against loss of income due to nonoccupational disability, there are two criteria of primary importance in determining eligibility benefits: the claimant must be a bona fide member of the labor force, and the disability must be of such a nature as to render him incapable of working.

Among the four states there are two basic methods for determining whether or not the claimant is an active member of the

labor force. The first is the wage test. A California claimant is required to have had minimum earnings of $750 during the base year before he became disabled. The second is the weeks-of-employment test, exemplified in the New York law, which specifies that the worker must have been employed for four consecutive weeks prior to the commencement of disability.

New Jersey formerly had only the wage test. Since 1953, however, it has required a combination of the two methods of qualification. It now requires the claimant to have established at least seventeen base weeks within the fifty-two calendar weeks preceding the week in which his disability commenced. A "base week" is any calendar week during which an individual earned not less than $15. This requires the claimant to have earned a minimum amount for a minimum number of weeks. The requirement that the claimant must have earned thirty times his weekly benefit amount in the base period, which is used in Rhode Island and is the alternate criterion used in California, is also a combination of the above two tests. This criterion not only requires a minimum amount to have been earned, but the minimum is so large that the practical effect is to require that it had to be earned in more than one quarter.

Each test has been subject to criticism. The wage test operates to disqualify lower paid workers, seasonal employees, and new recruits to the labor force. The New York provision may disqualify newly hired workers, as well as those returning to work after a lay-off. Labor has been particularly critical of the weeks-of-employment requirement in the New Jersey amendments. These amendments, it is claimed, have served to decrease markedly the number eligible for benefits, particularly cannery and resort workers, both of which are numerous in New Jersey. It is possible, with these amendments, for a worker to have earned several thousand dollars in the preceding year, clearly identifying him as a member of the labor force, and still be disqualified for benefits if the wage period was less than seventeen weeks.

Some length-of-employment qualifications are desirable, however. The program should have safeguards against those who would accept covered employment for a short period in order to

qualify for disability benefits. Inequities can be minimized by keeping the requirements low. The test of four weeks of employment would seem to be a fair one. Trends of future legislation may well depend upon how closely these disability programs are integrated with unemployment compensation. The wage tests are patterned after, and in some cases are identical with, unemployment compensation practices.

The second criterion—assurance that the claimant is incapable of performing his customary or most recent work—is met in each state by requiring medical certification for all initial claims. This certificate includes a diagnosis of the disability and an estimate of the length of time it will prevent the claimant from performing his work. Certification raises certain issues that will be discussed in Chapter 10.

Definition of Disability

Since disability insurance is intended to provide cash indemnity for wage loss due to disability, the definition of disability is of major importance. The definition should not be in medical terms, but rather in terms of ability to work. Many people have disabilities for which they receive regular medical treatment, but continue to work.

Since emphasis in these programs is on temporary disability, incapacity for work should be defined as the inability of an individual to perform his customary or regular work. Such a definition recognizes that the disabilities are brief and that in most cases the worker will return to his same job. It is unreasonable, and usually economically undesirable to expect a worker to change jobs for a short period because of a disability. A definition in terms of inability to do any work, if strictly interpreted, would also be difficult to apply. California, Rhode Island, and New Jersey use "inability to perform regular or customary work" or "inability to perform duties of his employment." The New York law reads differently—"inability to perform duties of his employment or any other employment his employer offers him at his regular wages and which his disability does not prevent him from performing."

California and Rhode Island use the same definition for claimants unemployed at the time they become disabled as they do for employed claimants. For the unemployed, New Jersey and New York use "inability to perform *any* employment for which he is reasonably qualified." Although few problems have arisen with either definition, probably because of similar interpretation, the latter, in keeping with unemployment compensation practices, would probably facilitate co-ordination with the unemployment compensation program.

Whether or not benefits are granted for pregnancy depends upon the definition of disability. Inasmuch as pregnancy benefits have been the subject of considerable controversy they will be discussed in more detail later.

Disqualifications

Disqualification provisions have also been subject to controversy. Rhode Island disqualifies only those claimants guilty of fraud and misrepresentation in the filing of claims. It is difficult to find fault with such a provision. The other state programs have incorporated into the disability program substantially the same disqualifications developed in unemployment compensation; e.g., a disability claimant is also disqualified for disability benefits if he is disqualified for unemployment compensaton because of a labor dispute. Curiously enough, this is true even in New York, where the disability insurance program is administered by the Workmen's Compensation Board. Disqualification provisions in unemployment compensation are intended to prevent payment of benefits for unemployment due to the individual's voluntary action rather than to lack of work. When an unemployed individual becomes disabled, however, it is evident that subsequent unemployment is immediately due to the disability. This is true even where a worker becomes disabled immediately after quitting a job without good cause. If he had not quit and were still working when he became disabled he would still be out of work because of the disability. Since the wage loss is not a consequence of the individual's voluntary action, disqualifications designed for un-

employment compensation are not appropriate for a disability insurance program.[1]

The New Jersey and New York laws, and some proposed legislation, exclude payment for periods of disability due to intentionally self-inflicted injuries, or to injuries sustained in the performance of illegal acts. While such a provision seems reasonable, the small number of such cases and the difficulty in determining the source of the disability suggest its undesirability. A somewhat similar provision was added to the California law in 1953, stating that, "An individual shall be disqualified from receiving benefits under this part while he is confined, pursuant to commitment or court order or certification, in an institution or other place, as a dipsomaniac, drug addict or sexual psychopath."[2] There is some justification for such a provision and it should be easy to administer.

BASIC CASH BENEFITS

No group has proposed that disability benefits should completely replace lost income; but a myriad of proposals, some seemingly just short of this goal, have been made at one time or another. The amount of benefits to be paid has probably received most legislative attention.

Benefit Formula

The purposes of the benefit formula are to measure the amount of the wage loss and to determine the proportion of it to be compensated. The latter has been the more controversial problem and will be discussed later. This section will discuss problems of determining the amount of wage loss experienced during disability. Some comments will also be made on provisions restricting utilization of benefits.

State disability insurance programs integrated with unemploy-

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[1] Harry Becker, "Recent Developments in Employee Disability Programs," *Journal of the American Association of University Teachers of Insurance*, March, 1950, p. 46.

[2] California Unemployment Insurance Code, 1953, Section 2678.

ment compensation originally used the same benefit formula for both programs. This formula was designed for the unemployment compensation program. The wage period most commonly used in this type of formula is the first four of the last five completed calendar quarters immediately preceding the first day of disability. Since wage records are usually reported by the employer quarterly, use of the first four of the last five completed quarters assures that all required records will be on hand when the claim is filed. Waiting until the most recent employer sends in the claimant's wage records is eliminated; consequently, benefits can be paid more promptly. The quarter of highest earnings is selected from this base period (first four of the last five completed quarters) and the amount of weekly benefit is usually one twentieth of these earnings.[3] The high-quarter concept endeavors to establish benefits in proportion to representative earnings, rather than penalize the claimant for recent earnings which may have been unusually low.

Despite the justification for the formula, it led to considerable dissatisfaction. With this formula benefits can be based upon a wage history more than a year old. This could encourage malingering during periods of falling wages. Labor has complained that the formula is not responsive during periods of rising wages. These dissatisfactions led to changes in New Jersey. Since 1953 New Jersey has based benefits upon the average weekly wage earned during the eight weeks immediately preceding the week in which disability commenced. New York has had a provision similar to New Jersey's since the outset of its plan. Insurance carriers use a recent wage period, provided use of such a formula gives the claimant benefits at least as large as those which would be granted him by the state fund concerned. Many have expected that California would amend its law in this respect. Future legislation will probably incorporate a formula based upon recent wage periods.

Another concept drawn from unemployment compensation is

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[3] One twentieth of quarterly earnings is designed to give a benefit approximately two thirds of average weekly wages. The weekly benefit will be less than this proportion for one who has worked less than thirteen weeks during his high quarter.

that of the "benefit year." This is a one-year period, usually beginning with the day a valid claim is filed, during which benefit rights based on base-period wages may be exercised. For example, with a twenty-six-week duration, a claimant is limited to twenty-six weeks of benefits in the twelve-month period following his initial disability filing date.

Rhode Island originally had a fixed or uniform benefit year, which provided that all claimants begin their benefit year the first Sunday in April. With this provision many claimants who had exhausted their rights in one benefit year were again eligible during the new period.[4] These continued claims, in addition to the usual number of new disabilities, resulted in a peak claim load during the spring and summer months, contrary to the usual incidence of disabilities. This was pointed out by critics as an indication of widespread malingering. The 1950 amendments provided for a flexible benefit year; i.e., the claimant's benefit year begins the day a valid claim for benefits is filed. Recent claim experience has been "normal," which suggests that the former claim load in the spring and summer months was due to the provisions of the law rather than to malingering.[5]

The uniform benefit year had a more serious shortcoming than its responsibility for an abnormal claim load. This provision permits one claimant, whose disability continues through two benefit years, to receive greater benefits than another claimant with a similar disability which was restricted to one benefit year. For example, suppose that two individuals were ill and were disabled for fifty-two weeks. It would be possible for one to collect benefits for fifty-two weeks while the other could collect for only twenty-six weeks, yet the only factor that differs in the two cases is the date upon which the workers became sick. If the one claimant became ill early in April he could draw a maximum of twenty-six weeks of benefits, because that would exhaust all of the credits

[4] This was possible because benefits received during the first benefit year were based upon the preceding year's earnings; wage credits may also have been earned the same year disability commenced, for which benefits were paid during the succeeding benefit year to those claimants who were still disabled.

[5] Rhode Island Department of Employment Security, *17th Annual Report* (1952), p. 26.

to which he was entitled in that benefit year. If the other claimant became ill early in October he could file a claim and draw the maximum of twenty-six weeks of benefits, then file a claim in the new benefit year (based upon wage credits earned during the preceding year) and receive benefits for twenty-six weeks more. The provision also permitted individuals who had left the labor market to receive benefits up to two years after such withdrawal. These inequities influenced the legislature to enact the above-mentioned changes.

California grants the maximum duration for each disability. In contrast, benefits are limited in New Jersey and in New York to a consecutive fifty-two week period, commencing with the onset of disability.

In summary, since disability benefits are intended to replace temporarily interrupted earnings, they should be based upon a recent wage period. Future legislation will probably contain a formula providing for benefits on that basis. And while supporting data are not available, it would seem that elimination of the benefit-year concept could be effected for little additional cost. The additional benefit cost, if any, would be offset, in part, by simpler administration. In any event, such a change would be more favorable to claimants and would tend to better meet the need for which the programs were designed.

Waiting Period

In framing a system of cash disability benefits, a waiting period between the onset of disability and the commencement of benefits is desirable. There are three good reasons for such a provision. First, the majority of all disabling illnesses last only a few days.[6] Most workers lose at least one, two, or a few days of work each year on account of disability. These losses are so small that no great financial hardships result from them. Second, to pay benefits from the first day of disability encourages some to take advantage of insurance. Third, the cost of the program is greatly reduced by a waiting period. Although the individual short-term claim is for

[6] W. M. Gafafer, "Sickness Indemnification," *Sickness Indemnification*, Transaction Series, Bulletin No. 1 (Industrial Hygiene Foundation, 1944), pp. 24–26.

a small amount, the aggregate is a considerable sum. The administrative costs of handling a large volume of small claims is also an important factor. Consequently, it is advisable to have a noncompensable waiting period.

It has been asserted that a short waiting period, or none at all, will encourage workers to rest at the onset of a disability, thus hastening recovery or preventing the development of more serious complications. This assertion is not so reasonable as it sounds; indeed, there are several studies that lead one to question it. One study indicated that insured groups with a three-day waiting period had, in total, 29 per cent more sick claims extending beyond a two-week period than did groups receiving benefits after a seven-day waiting period.[7] Another study showed that a group having a benefit plan with no waiting period had more than twice the people out of work on the fourth day of disability as did a group with a three-day waiting period. And these two groups had from 40 per cent to 87 per cent more people out on the eighth day than did a third group with a seven-day waiting period.[8] If the short waiting period does in fact reduce the seriousness of disability in certain cases, these studies suggest that it also encourages abuse of the benefit program.

Length of the waiting period is one of the most important determinants of costs. Experience has shown that a plan with no waiting period may cost twice as much as one with a waiting period of seven days.[9] A three-day waiting period may cost about one quarter more than one for seven days. Some insurance companies offer a plan that pays benefits for accidents from the first day, but requires a waiting period of seven days for illness. This variation costs about 10 per cent more than a seven-day waiting period for both accident and sickness.[10] A waiting period of seven

[7] Andrew T. Court, "The Economic Basis of Health," *Sickness Indemnification*, Transactions Series, Bulletin No. 1 (Industrial Hygiene Foundation, 1944), pp. 11–12, 16.

[8] National Industrial Conference Board, *Compulsory Sickness Compensation for New York State* (1947), pp. 124–26.

[9] *Ibid.*, p. 124.

[10] Henry S. Beers, "Underwriting Principles in Sickness Disability Insurance," *Archives of Industrial Hygiene and Occupational Hygiene and Occupational Medicine*, December, 1950, p. 652.

days costs about 30 per cent more than a waiting period of fourteen days.[11]

All state plans have seven-day waiting periods. In California, New Jersey, and New York the waiting period applies to each disability. Consecutive periods of disability due to the same or related cause, and separated by not more than a short period,[12] are subject to only the initial waiting period. Rhode Island, on the other hand, requires but one waiting period each benefit year. This means that a worker must be disabled for eight days or more before being eligible for benefits for his first disability, but for the next twelve-month period he receives benefits from the first day of any disability, provided the second disability lasts at least seven consecutive days. The practice of requiring a waiting period for each period of disability has been criticized as imposing a hardship upon the worker unfortunate enough to suffer several disabilities within a year. Conversely, the Rhode Island provision has been said to be overly liberal and one that leads to abuse.

In those states which have had large surpluses in the state fund, labor has frequently submitted bills providing for a shorter waiting period. These bills have often provided for the elimination of the waiting period for disabilities arising out of accident. This change, which could be provided for little cost, probably would not encourage abuse.

Future legislation will probably provide a waiting-period provision similar to that found in the New York plan. The seven-day period is short enough to prevent an undue financial burden upon workers and long enough to exclude many minor illnesses that increase the costs and problems of administration. The elimination of the waiting period for consecutive periods of disability ameliorates the difficulties in most of the "hardship cases."

Level of Benefits

Proportion of Wages. The purpose of the benefit paid during temporary disability should be to tide the worker over a tempo-

[11] New York Department of Labor, *Studies in Disability Insurance* (1949), p. 137.

[12] Fourteen days in the California and New Jersey plans and three months in New York.

rary interruption in earnings with as little change as is practicable in his usual standard of living. Benefits should therefore be a substantial proportion, e.g., one half or two thirds, of the individual's average earnings. Full compensation, however, is usually not considered advisable, particularly since disability insurance benefits are not subject to the federal income tax. Benefits which approximate the worker's regular income may reduce his incentive to return to work. Therefore, a substantial margin should be maintained between benefits and what can be earned by employment.[13]

As has been true of other social insurance programs in America, benefits in temporary disability insurance have been geared roughly to each worker's earnings, rather than a flat dollar amount for all workers.[14] Usually a goal of approximately one half to two thirds of earnings is sought, with minimum and maximum dollar limits. Disability insurance benefit levels have usually been the same as those for unemployment compensation in each state. The minimum weekly cash payment in each of the four state laws is $10. In New York, however, the minimum weekly benefit may be lower than $10, if weekly earnings are less than $10. The maximum weekly benefits vary from $30 in Rhode Island to $40 in California.[15] Within the minimum and maximum limits the worker's weekly benefit rate varies with the amount of wages earned during a preceding base period. For example, in Rhode Island one twentieth of high-quarter wages,[16] rounded to the nearest dollar, is paid weekly; in New York, the benefit is one half of the average weekly wage earned in the last eight weeks of covered employment prior to commencement of the disability.

In California the benefit amount is determined by a table which relates specific weekly dollar benefits to high-quarter wages. For example, a claimant with high-quarter wages of between $350

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[13] Malingering, though overstressed by some writers, is a factor that must be considered in wage-indemnification insurance. The major safeguards are usually benefits which are less than wages, and eligibility provisions which are intended to assure that the claimant is normally part of the labor force. See Chapter 10.

[14] Flat rates have been used in Europe—particularly in Great Britain.

[15] The New Jersey law limits the benefit amount to $30, while the New York law specifies $40. The railroad plan limits benefits to $7.50 per day.

[16] One twentieth of a quarter's wages per week is almost two thirds of the average weekly wage.

to $374.99 receives a weekly benefit of $19. This table is arranged to grant the lowest paid workers benefits approximating 90 per cent of average weekly wage, whereas claimants with an average weekly wage of $60 receive approximately 60 per cent. Prior to January 1, 1953 New Jersey used a high-quarter formula. Since that time benefits have been set at two thirds of the claimant's average weekly wage, based upon earnings of the eight weeks immediately preceding the disability. These changes, which base benefits upon a more recent wage history, indicate a trend away from the unemployment compensation formulas.

Maximum Benefit. Most of the contention in relation to level of benefits has had to do with the amount of the maximum benefit, probably because of the great disparity between the benefit maximum and the average take-home wage. Proposals for increases have usually originated with labor groups and have been opposed by employer groups and the insurance industry. Labor's stand needs no explanation. Employer groups have usually opposed benefit increases, even in states where no employer contribution is required, for fear that higher benefits for temporary disability would encourage demands for increased unemployment compensation and workmen's compensation benefits, which are financed by employers. The insurance industry has opposed benefit increases, particularly in states with a flat percentage contribution, i.e., no experience rating, since any increase in benefits decreases the operating margin.[17]

Rhode Island initially had a maximum benefit of $18, which was increased to $25 in 1949 and to $30 in 1955. This is a low standard, and there have been occasional proposals by labor that it be raised. However, organized labor in general feels that since other provisions of the plan are generous, an increase in maximum

[17] Sometimes insurance industry legislative groups have gone along with labor in supporting benefit increases in exchange for labor support of other proposals. A marked departure from this took place in California a few years ago when labor groups, aroused by the "unreasonable" resistance exerted by the insurance industry to proposed benefit increases, instituted a "boycott" of private insurance contracts. They actively solicited members to encourage them to refuse private insurance plans (in California each employee may choose to be covered by a private plan or by the state plan). Fortunately for the insurance companies, the boycott was relatively ineffective. Two years later the two groups were again co-operating in legislative proposals.

benefit may jeopardize the solvency of the fund. Consequently, no strong legislative pressures have been exerted.[18]

The California plan originally provided maximum benefits of $20, which was increased to $25 in 1948, to $30 in 1952, to $35 in 1954, and to $40 in 1955. New Jersey provided a maximum benefit of $22 in the original law. An amendment in 1950 raised this to $26, another in 1952 increased it to $30, and the current maximum of $35 was provided in 1955. New York started with a maximum of $26, which was increased in 1952 to $30, in 1954 to $33, and in 1956 to $40.

Notwithstanding these consistent increases, most labor groups contend that maximum benefits are still inadequate, particularly for the higher-paid worker. It is claimed that a disability benefit of $30 or $40 has little relationship to a weekly wage of $100, a common wage today. It has been pointed out, on the other hand, that the higher-income groups are often among those whose salary is not stopped during a temporary disability. They are in a position, too, to purchase commercial insurance to supplement the statutory benefit. Moreover, it has been argued that social insurance is designed to provide a minimum subsistence, and that people should be encouraged to supplement this on their own initiative.

Co-ordination with Other Social Insurance. Benefit schedules in temporary disability insurance, unemployment compensation,[19] and workmen's compensation should approximate each other. Failure to keep them in line may shift a burden on to the program with the highest benefit schedule. An unemployed worker in a state with unemployment benefits lower than temporary disability benefits (not usually the case, however), for example, collecting $30 a week from unemployment compensation and realizing he might qualify for $35 from temporary disability insurance,

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[18] During 1952 and 1953 benefits paid exceeded taxes collected, but interest on the reserve fund made up the deficit. The high benefit ratio in Rhode Island has been attributed to pregnancy benefits and the right to receive disability and workmen's compensation benefits or wages concurrently (discussed later).

[19] Of the three state disability insurance programs co-ordinated with unemployment compensation, California is the only one with a benefit-schedule difference between the two programs. Disability benefits are higher.

may get "sick" to claim the higher benefit. A disabled worker, on the other hand, often has doctor bills and other medical expenses which the unemployed worker does not have, so that in the absence of medical-care benefits, it has been suggested that weekly indemnity benefits for disability insurance should be higher than those for unemployment compensation to make up for those added costs.[20] This has been countered by pointing out that during the latter part of convalescence there may be no extra expenses; indeed, there may be odd jobs around the house that the recuperating patient can do and thereby save repair bills.[21]

Dependents Benefits. It has been suggested that disability benefits should be increased by adding allowances for dependents.[22] Existing laws, it is argued, fail to recognize that the hardships of disability fall on the family, not merely on the individual. And no one will question the greater need of individuals with dependents. Precedents for such provisions are to be found in both unemployment compensation and workmen's compensation.[23] Such provisions should not create difficult administrative problems. Financing such benefits is probably the most difficult problem to be solved in considering such legislation.

Private Plan Difference. Plans underwritten by insurance companies have usually paid higher benefits than the statutory minimum.[24] The differences have often been as much as ten or fifteen dollars a week, with no increase in premium.[25] As the statutory benefits have been increased, however, the margin between them and the benefits paid under private plans has decreased. This trend has been most noticeable in California, where

[20] Statement submitted by International Ladies' Garment Workers' Union to the New Jersey State Commission on Post War Economic Welfare.

[21] Beers, *op. cit.*, p. 653.

[22] Wilbur J. Cohen, "New Developments in Employee Disability Programs," *Journal of the American Association of University Teachers of Insurance*, March, 1950, p. 35. Also *Yale Law Journal*, *op. cit.*, p. 659.

[23] Twelve states provide dependent's benefits under workmen's compensation, and eleven states under unemployment compensation.

[24] This has been particularly true in California since the 1 per cent contribution has, in the past, been in excess of that needed to pay statutory benefits. The state fund, in paying statutory benefits, has accumulated a large surplus.

[25] Some believe the companies have made a mistake in following this practice. They claim that labor, noting the higher benefits being paid by the companies for the same premium, will insist that the administrators of the state fund do likewise.

there has been a fixed percentage contribution and the benefit increases have been greatest. During the early years of the law in California, the companies had no difficulty in complying with the "greater-than" benefit provision[26] since weekly benefits were usually considerably in excess of those required. Recently the differences in benefit level have decreased sharply. In 1953 one company received permission to write a plan in which the only benefit granted which exceeded the statutory minima was a hospital benefit of thirteen days rather than twelve, for which the company admitted there would be a negligible cost.[27]

Summary. Some believe that pressures for benefit increases will diminish as state fund outgo equals or exceeds income. Labor insists, with some justification, that rising prices and wages should be accompanied by increases in benefits. These increases can best be made in states with fixed percentage contributions by increasing the taxable wage base, e.g., from $3,000 to $3,600.[28] If workers are willing to pay the cost, benefits can probably be increased to as much as two thirds of average weekly wages without creating undue administrative problems. Benefits must, however, be subject to a maximum. A maximum approximating two thirds of the statewide average wage would seem to be equitable.

Maximum Benefit Duration

The most common maximum benefit for temporary disability is twenty-six weeks, which seems reasonable. Although the twenty-six-week limit is not sufficient for all claimants (nor is it intended to be), the 1952 experience of the California plan has indicated that almost 90 per cent of disabilities terminate within the twenty-six week period.[29] Prior to the advent of the compulsory programs, most voluntary plans provided a thirteen-week duration. Today the majority of the voluntary plans provide benefits for

[26] Section 3254 of the California Unemployment Insurance Code requires that the rights afforded covered employees under private plans must be greater than those provided by the state fund.

[27] Interview with Milton Monasch, representative of the Transportation Insurance Company, August 27, 1953.

[28] The present tax base of $3,600 in Rhode Island was raised from $3,000 in 1955.

[29] California Department of Employment, *Report 1031A #4*, August 7, 1953.

twenty-six weeks. This extension has been attributed, in part, to the influence of the compulsory programs. The doubling of the duration period is responsible for approximately a 20 per cent increase in cost.[30]

Benefit duration in Rhode Island was first computed by dividing the total benefit credits (which were determined by total earnings in the base period) by the weekly benefit (which was determined by a schedule related to the high quarterly earnings in the base period). Benefit duration ranged from 3.9 weeks to 20.25 weeks. Amendments in 1949 increased the weekly benefit rates and total benefit credits; maximum benefit duration was increased to twenty-six weeks. California originally had the benefit duration vary from 12.5 weeks to 26 weeks, depending upon base-period wages. Amendments effective in 1954 changed this to a uniform twenty-six-week duration. The New Jersey law first provided for a benefit duration varying from 10 to twenty-six weeks, depending upon base-period wages. Since 1953 maximum duration is determined by three fourths of the number of weeks worked during the year prior to onset of disability ($15 or more must have been earned each week), with a minimum of thirteen and a maximum of twenty-six weeks. New York formerly had a uniform potential duration of thirteen weeks, which was changed, in 1956, to twenty weeks.

There has been criticism of the benefit duration formulas in Rhode Island and New Jersey. Use of these formulas causes the lower-paid workers to receive benefits for a shorter duration than their higher-salaried co-workers. The following table indicates how a worker would fare under the Rhode Island plan.[31]

Wages Earned in Base Year	*Total Benefit*	*Weekly Benefit*	*Duration of Benefits (in Weeks)*
$ 300	$104	$10	10 plus
700	208	12	17 plus
1,000	286	15	19
2,000	546	25	21
2,400 or over	650	25	26

[30] New York Department of Labor, *op. cit.*, p. 143.

[31] These figures are taken from Rhode Island Temporary Disability Insurance Act, Section 5, Tables A and B. Duration is determined by dividing the weekly benefit into total benefits.

Since the lower-paid workers have the greater need for benefits, such a restriction appears to be unwise. The twenty-six-week maximum duration should apply to all workers, regardless of past wages.

The former limitation of thirteen weeks in New York has also been subject to criticism. The majority of disability claims are terminated within thirteen weeks. Nevertheless, there are a large number of valid claims for extended benefits which are not terminated within that time, and in such an event a need for benefits persists. The experience in California indicates that only 73 per cent of claims were terminated within thirteen weeks.[32] Since the maximum benefit duration can be doubled for a 20 per cent increase in cost, it would seem wise to do so. Future legislation will probably provide a uniform maximum duration of approximately twenty-six weeks.

Effect of Other Income on Benefits

Since temporary disability insurance programs provide relatively low benefits, encouragement should be given to supplement these benefits by individual or group action. At the same time, legislation should be drawn up so that duplicate payments are not received from other social insurance programs for the same disability. To achieve this, supplemental payments should affect qualification for receipt of disability benefits differently, depending upon the source of the payments.

Wages. The Rhode Island law has always ignored all wages paid while the claimant is not working. During the early years of the plan's operation this created problems; it is now felt, however, that most employers have adjusted wage payments in order to reduce this problem.

New York formerly reduced benefits by any amount received from the employer or from any fund to which the employer contributed. This restriction was eliminated in 1955.

New Jersey and California provide that benefits plus wage payments cannot exceed wages. California originally limited benefits

[32] California Department of Employment, *op. cit.*, p. 10.

plus wages to the weekly benefit amount; a 1952 amendment increased the combined limit to 70 per cent of wages, while a 1955 amendment increased this limit to full wages.

Difficulties have arisen in deciding whether payments are wages or gratuities. Wage-continuation plans, for example, under which the weekly amount paid by the employer varies with the duration of the disability, have created difficulties in the adjustment of the disability benefit.

An individual receiving wages which are remuneration for services actually performed should not be eligible for disability benefits for the days on which he performed the services. On the other hand, there should be a minimum of restrictions on voluntary efforts to supplement disability benefits. This can be achieved, according to one opinion, by permitting only supplementary benefit payments made under a formal wage-continuation plan. But many similar payments are made at the discretion of the employer or under an informal plan, and to allow only those payments made under a formalized plan would often put undue emphasis upon terminology. It is suggested that all wage continuation payments should be treated in the same manner as voluntary group disability payments, i.e., they should not restrict receipt of statutory benefits in any way. This assumes that the employer, most interested in reducing malingering, will devise a workable benefit schedule. While this procedure will not eliminate all problems arising from receipt of excessive income during disability, it seems preferable to have the employer make the necessary adjustments rather than to require adherence to inflexible statutory requirements.

Workmen's Compensation Benefits. The fact that workmen's compensation and temporary disability insurance indemnify the same working population, by and large, for loss of wages due to disability makes it particularly important that these two programs be effectively co-ordinated. Establishing the cause of disability is the primary distinction between the two. It is often difficult to determine whether or not a disability is work connected. When administered by different agencies, the decisions of the agencies may differ, permitting some disabilities to be com-

pensated under both programs, and perhaps others under neither.

To eliminate qualification gaps between the two programs the claimant should be permitted to file a borderline claim under the temporary disability insurance program, but he should be required to reimburse the disability fund in the event that workmen's compensation is awarded. Such a provision, however, should not make it possible to use the disability program to compensate for inadequacies in coverage or other defects of the workmen's compensation law. To the extent that disabilities, compensated under the disability program should have been indemnified under workmen's compensation, there has been subsidization of the one program by the other. This may result in a shifting of costs of work-connected disabilities from the employer-financed workmen's compensation program to the temporary disability insurance program, which is particularly inequitable when disability insurance is not financed entirely by the employer. An incidental result is that it relieves pressures which should be applied in order to effect desirable changes in the workmen's compensation laws.

The restrictions on duplicate benefit payments suggested above refer, of course, to benefits received for the same disability. It is possible for a worker to receive benefits under both programs which would not be deemed undesirable. For example, a worker who, returned to employment, is receiving workmen's compensation benefits for a permanent partial impairment should also be eligible for benefits under the disability program for a temporary disability. A claimant with pneumonia who is receiving workmen's compensation for the loss of a leg several years earlier[33] is one such case in point. Permanent partial or total disability benefits for a disability of prior origin are indemnities for a decrease, actual or presumed, in earning power, while temporary disability insurance benefits represent indemnities for current loss of earnings. In such cases, receipt of workmen's compensation benefits for another disability should not bar a claimant from receiving temporary disability insurance benefits.

[33] U.S. Department of Labor, *Temporary Disability Insurance Problems* (1953), p. 40.

Labor, in states with no employer contribution to the disability program, has expressed the opinion that duplication of benefits from the two programs for the same disability is desirable.[34] It justifies this stand on the ground that since the worker has supported the temporary disability program exclusively, he is therefore entitled to "his" benefits whether or not he collects workmen's compensation for the same disability. It is further argued, by analogy, that if the worker is injured in an off-the-job automobile accident, disability benefit rights are not endangered if he subsequently collects damages in court covering his injuries in such accident.

Workmen's compensation benefits have proven to be a source of considerable trouble to the Rhode Island program. The original law adopted in 1942 provided that any person receiving benefits under the workmen's compensation law was disqualified from receiving disability benefits unless the workmen's compensation benefits were less than the disability claimant would receive from the disability fund; in which case an amount equal to the difference in benefit was payable by the disability program. This provision was bad enough, in that the disability insurance program subsidized inadequacies in workmen's compensation, but in 1943 the legislature amended the Act so that claimants could receive workmen's compensation and disability benefits concurrently. The effects of this amendment are adequately described in the first annual survey of the Rhode Island program:

> In an effort to determine the cost to the fund for paying benefits to persons who were receiving Cash Sickness and Workmen's Compensation benefits simultaneously, a statistical inquiry was ordered by the Board. In this study the Cash Sickness records were checked against those in the Workmen's Compensation division of the Department of Labor.
>
> It was found that 25.3 per cent of those who collected benefits from both sources simultaneously received a total amount which exceeded the full time weekly wage which they would have earned had they been able to work. In addition all medical expenses of these claimants were borne by the insurance company or the employer.
>
> On the basis of the evidence collected in the survey it was estimated

[34] Nathan Sinai, *Disability Compensation* (Ann Arbor: University of Michigan School of Public Health, 1949), p. 28.

that the cost to the Cash Sickness fund of paying benefits to workers during the time they were also receiving Workmen's Compensation was $315,000 in the first benefit year.

In addition to the benefits which they collected while they were disabled by industrial accident or disease, many of these claimants also received compensation at a later date for illnesses not connected with their employment. An analysis of the amount paid to these workers during the entire benefit year showed that 91.8 per cent of the payments were for industrially caused illness and only 8.2 per cent of the payments were for non-industrial illness.

However, the amount which was paid for the non-occupational illnesses was relatively low, because a number of the workers drew the bulk of their Cash Sickness credits during the period of their industrially caused disability and hence had no, or only limited, credits to draw upon later in the year when they were ill from other causes.

In such cases as this, the workers received during one period of illness more than they could have earned while working and later in the year when they were ill from a different cause, they were unable to collect benefits from either source.[35]

Thus, the disability insurance program permitted some workers to receive a greater income while disabled than when they were working, a condition conducive to malingering. In addition, it permitted workers to exhaust their disability insurance benefits while receiving workmen's compensation benefits, thus defeating the purpose of the disability insurance program.

Despite the highlighting of the above condition by the administration, no action was taken by the legislature until 1946. At that time amendments were passed restricting combined benefits from workmen's compensation and disability insurance benefit to 90 per cent of the claimant's average weekly wage at his last regular employment, the disability insurance benefit to pay the excess over workmen's compensation. The 1949 amendments later reduced this to 85 per cent. These amendments have ameliorated the problem to some extent, but serious shortcomings remain. Only those claimants receiving both benefits concurrently are subject to the percentage limitation. When workmen's compensation benefits are paid in a lump sum the rule does not apply. Nor is

[35] Rhode Island Department of Employment Security, *9th Annual Report* (1944), pp. 15–16.

the rule effective when workmen's compensation claims are delayed in settlement. During this period of delay a claimant is entitled to full disability benefits with no right of recovery on the part of the state fund.[36]

Other states have profited from Rhode Island's early experience with workmen's compensation benefits. The California law prohibits disability benefits if workmen's compensation benefits are being received for the same disability, unless the latter benefits are less than disability benefits, in which case the difference is payable from the disability fund. New Jersey and New York workers are not eligible for disability benefits during any period in which workmen's compensation benefits, other than permanent partial benefits for a prior disability, are paid or are payable.

Voluntary Insurance Payments. No voluntary insurance payment should be considered in determining eligibility for statutory disability benefits. Social insurance is designed to provide basic protection. Any voluntary efforts, whether group or individual, to supplement basic protection is to be encouraged. None of the existing plans considers voluntary insurance payments in determining statutory benefits.

One of the problems that has arisen in this area is how to supplement monopolistic state fund benefits with voluntary commercial insurance. Very little group weekly indemnity insurance has been sold in Rhode Island. The reasons for this are well stated by Mr. Edmund B. Whittaker, of the Prudential Insurance Company of America:

> In any case, a state monopoly with a fixed maximum is a deterrent to the higher paid skilled workers. If an employer whose employees earn on the average $70 a week wants to provide a sickness benefit of half pay, or $35 a week, and his employees are insured under a compulsory plan providing a maximum of $25 a week, it would be quite difficult for him to insure the other $10 a week because no insurance company would want to write it. In the first place, insurance companies are quite sensitive about their retentions for expense, and the expense charges for a $10 a week benefit would not be very different from those for a $35 a week benefit. In the second place, there would be total confusion between the claim admin-

[36] Rhode Island Department of Employment Security, *10th Annual Report* (1945), p. 24.

istration in the state plan which provided the first $25 a week and the insured plan which provided the other $10 a week. Unquestionably, with the present margin in the state plan for expenses the administration would be more apt to be lax under the state plan than under the private plan where the employer cooperated in claim administration. If employees were to collect under the state plan but not under the private plan bad relations for the insurance companies would certainly follow. That explains the reluctance of Group Insurance companies to superimpose private coverage on the Rhode Island state monopoly.[37]

Other Types of Payments. Unemployment insurance provisions have an "able to work" clause which eliminates most possibilities of benefit duplication with temporary disability insurance. Nevertheless, these programs are not always mutually exclusive; hence the law should provide that no claimant is entitled to receive both benefits for the same week.

Benefits from other temporary disability insurance programs should be excluded. OASI, railroad retirement, or other governmental retirement payments should not be taken into account in determining disability benefits. The New Jersey plan, however, reduces disability benefits by the amount of any pension benefit to which the most recent employer contributed.

Trends. Rhode Island's unfavorable experience with "other-income" provisions will probably influence future legislation. Duplicate payments for the same disability by workmen's compensation will probably not be permitted. OASI benefits will probably not be considered in determining the disability benefit. No restrictions are likely on voluntary efforts to supplement the statutory benefits.

OTHER BENEFITS

What benefits, other than cash for loss of time, should be granted under a temporary disability insurance program? This question has plagued legislators and administrators of the laws. Is it possible to provide pregnancy benefits? If so, to what extent? Should medical-care benefits be added? Should any responsibility

[37] From an address before the Fall Insurance Conference of the American Management Association, Chicago, November 17, 1950.

for the disabled unemployed fall on the temporary disability insurance program?

Pregnancy-Maternity Benefits

There is a stock question often asked of neophytes in accident and sickness insurance. Is pregnancy to be classified as an accident or a sickness? Pregnancy benefits are, however, not a source of humor in temporary disability insurance, and an incorrect policy can lead, and has led, to serious administrative and financial problems.

It is agreed that pregnancy as such is not necessarily a disabling illness. One employed expectant mother will work almost to the day of delivery; another may stop as soon as her pregnancy is established. Although many work absences during pregnancy are due to physiological factors, many too are due to psychological factors, and even to custom and tradition. Where one woman may discontinue working during this period because of an actual inability to work, another may discontinue working because of fear or embarrassment.

The definition of disability should specifically state whether pregnancy is a cause of eligible disability, and if it is, under what conditions. There are several alternative policies in the treatment of pregnancy and related cases. One alternative is to accept pregnancy *per se* as a cause of disability. A second alternative is to pay benefits for maternity, as distinct from pregnancy. Maternity benefits, paid automatically, are cash payments for limited periods of time preceding and succeeding delivery. A third alternative is to exclude pregnancy or maternity benefits entirely.

Pure Pregnancy Concept. The first alternative is illustrated in the first years of Rhode Island's experience. This policy was "adopted" by default. No mention of pregnancy was made in the definition of eligible disability. Disabilities presumed due to pregnancy were compensated as from any other cause. Since women constitute a large proportion of Rhode Island's labor force, this resulted in a heavy claim load.[38] The financial drain

[38] During the war women constituted in excess of 40 per cent of Rhode Island's labor force. See Arthur P. Patt, *Labor and Disability Insurance* (1949), p. 8.

was a major reason for drastic changes in the Rhode Island law. In 1946 an amendment was passed restricting pregnancy benefits to a maximum duration of fifteen weeks, unless complications developed as a result of childbirth. Even this sharp curtailment did not achieve all that was expected, and in 1949 pregnancy benefits absorbed approximately 30 per cent of all benefit payments.[39]

Maternity Concept. Inasmuch as the Rhode Island program was in difficulty financially, it was deemed advisable to further restrict benefits for pregnancy. Another amendment was passed in 1951 to restrict pergnancy benefits to twelve consecutive weeks, beginning six weeks before the date of expectancy and ending six weeks following childbirth, except for unusual complications; thus qualifying these benefits as maternity benefits. Although the amendment reduced the claim load from this cause, payments for maternity continue to represent the largest outlay for any single diagnostic group. During 1955 maternity benefits amounted to more than 22 per cent of total benefits paid.[40] This is a large proportion of benefits to be paid for one cause of disability, but is representative of what may be expected when a state with a labor force analagous to that found in Rhode Island uses the second approach mentioned above.

The railroad plan has a very liberal maternity provision. Receipt of this benefit does not affect rights to any other benefits to which the claimant is entitled. These benefits are paid for 116 days; 28 of these days are paid at 1.5 times the regular rate. Since women make up only 7 per cent of the workers covered, these liberal benefits have not been a drain on the plan. During the 1951–52 benefit year, maternity benefits represented only 8 per cent of total benefits.[41]

Pregnancy Exclusion. The plans in California, New Jersey, and New York generally follow the third alternative and exclude pregnancy benefits entirely. In California there is one exception:

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[39] Rhode Island Department of Employment Security, *14th Annual Report* (1949), p. 24.

[40] Rhode Island Department of Employment Security, *20th Annual Report* (1955), p. 27.

[41] U.S. Department of Labor, *Temporary Disability Insurance Problems* (1953), p. 26.

benefits are payable for complications that extend beyond four weeks after delivery. New York has a similar provision: benefits are payable for complications which arise after the claimant returns to covered employment for at least two consecutive weeks following termination of pregnancy.

Conclusions. Few people would question that pregnancy-maternity benefits are in the interest of maternal and child health. But as Rhode Island's early experience proved, liberal definition of eligibility for pregnancy benefits is almost sure to be very costly. It is questionable whether even the maternity type of benefit should be included in a temporary disability scheme; as Rhode Island's recent experience shows, that too is costly. These benefits also frequently represent a "termination payment," since many women do not return to work after delivery. Many believe that payment of disability benefits to nonpermanent members of the labor force does not further the purpose of the program and should be prohibited.

Many disability insurance advocates believe that maternity benefits should be paid, but as part of a broad national health program, financed largely from general tax revenues. State disability plans should not be called upon to compensate for shortcomings in other social welfare programs.

To deny benefits in all cases of pregnancy constitutes discrimination against a significant group in the labor force. Many justify such action with the argument that female employees, even exclusive of pregnancy benefits, receive a relatively larger share of benefits than do male employees. However, to carry this argument to its logical conclusion would justify reducing benefits to low-income and upper-age groups, who are in a similar position.

Employer groups and the insurance industry seem to be indifferent to the issue of pregnancy benefits. Labor is divided, but the consensus is that higher weekly basic benefits would be preferable to granting benefits for pregnancy. Despite the many arguments for pregnancy benefits, they will probably be excluded from future legislation because of the financial and administrative problems they involve. After the plans have accumulated adequate surpluses, these benefits may be included on a limited scale.

Medical Benefits

Disability often has a twofold economic effect upon the disabled worker. At the very time that his regular income is stopped, he also incurs medical expenses. It is not unusual to experience medical expenses far in excess of lost wages. Without insurance against this hazard, the disabled worker must rely on charity, go into debt, or forego medical treatment at the risk of aggravating his disability.

The needs that brought about the development of disability insurance warrant also a provision for medical benefits.[42] Disability programs are designed to provide protection for relatively major disabilities since a seven-day waiting period is imposed and certification by a doctor is required. In the temporary disability insurance program for industrial workers there is an emphasis upon return to work as soon as possible. This is facilitated by early diagnosis and adequate medical treatment. Medical benefits, it is claimed, do not create the danger of malingering because while the claimant is assured needed medical attention, illness is not financially advantageous to him.[43]

The case for medical benefits, as an addition to cash for loss of time, in temporary disability insurance is strengthened by the experience under workmen's compensation laws. During the early years of this legislation emphasis was on cash benefits. But since the benefits averaged less than 50 per cent of wages, it was soon realized that little of the cash was being used (or could be used) for medical care and, as a result, disabilities were prolonged because of lack of medical attention.[44] Consequently, medical benefits were introduced. Increasing recognition of their importance accounts for the fact that today medical benefits are generally much more liberal than cash benefits. In fourteen states and in all the Canadian provinces medical benefits are now furnished

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[42] See Chapter 2.

[43] Leonard J. Goldwater, "Sickness Disability Insurance and Preventive Medicine," *Archives of Industrial Hygiene and Occupational Medicine*, December, 1950, p. 689.

[44] Arthur H. Reede, *Adequacy of Workmen's Compensation* (Washington, D.C.: Howard University Press, 1947), pp. 156–66.

without limit as to time or amount.[45] The individual with a temporary nonoccupational disability has just as much need for medical care as if his disability were of occupational origin.

The development of medical benefits in some European temporary disability insurance programs was similar to the development of medical benefits in workmen's compensation here. There, too, the initial emphasis was upon cash benefits. As the importance of medical benefits was realized, however, cash payments became a decreasing percentage of total benefits paid. Cash benefits are as little as one third of total benefit payments in some countries, with a relatively greater emphasis upon medical benefits.[46] Experience of workmen's compensation programs in the United States and of temporary disability insurance programs in Europe indicates that medical benefits should be given serious consideration for inclusion in state temporary disability insurance programs in this country.

Medical benefits were not included initially in any of the state plans in this country. A 1949 amendment to the California legislation provided hospital benefits of $8 a day for 12 days.[47] No waiting period is required for these benefits, nor for basic benefits for hospitalized disability claimants. An amendment in 1953 increased the daily hospital benefit to $10. The New York law makes no provision for medical benefits, but by administrative ruling medical, hospital, and surgical-care benefits may be substituted for cash benefits up to 40 per cent of the statutory scale of benefits. The New York ruling was received with mixed comments. Some hailed it as promoting desirable flexibility, while others condemned it as a spearhead for program expansion. Industry spokesmen have noted that this may be a means whereby

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[45] Chamber of Commerce of the United States, *Analysis of Workmen's Compensation Laws* (1954), pp. 39–40.

[46] Harry A. Millis, *Sickness and Insurance* (Chicago: University of Chicago Press, 1937), p. 89.

[47] This amendment was passed as an alternative to an increase in cash benefits. The legislature responded to insurance-industry and employer pressure by defeating a labor-sponsored bill for cash-benefit increases. Subsequently a bill providing hospital benefits was submitted and passed. This bill, although not sponsored by labor, was passed, it is believed, in an effort to appease labor after the defeat of the cash-benefit bill.

future benefit legislation, even in established plans, may provide hospital and surgical benefits.[48]

Labor, however, has not generally sponsored medical benefits. It has preferred that the medical-care problem be solved at the national level by a comprehensive health insurance measure. It believes that state action in this area might hamper passage of such legislation. Expansion and extension of medical benefits in state disability programs probably hinges on whether or not such federal legislation is passed.

Disability Benefits for Unemployed Workers

Temporary disability insurance is designed to replace income lost while the worker is unable to work because of disability. Unemployment compensation is designed to replace income lost while the worker is unable to work because there is no job. A problem arises when the disabled-unemployed worker is unable to satisfy the "able-to-work" requirement of the unemployment compensation law, and his loss of wages is not due to the disability.

Temporary disability insurance programs provide for the payment of benefits to the disabled unemployed. Under the Rhode Island plan and railroad plan disability benefits are paid when the worker fulfills all the necessary qualifications for unemployment compensation, other than of ability to work. These disability benefits are paid to unemployed as well as to employed workers from the same funds and on the same basis.

California also pays disability benefits to unemployed workers on the same basis as to employed workers. Financing of benefits for the two groups, however, is different. Benefits to the unemployed are paid at the statutory level from an "extended liability account." This account is financed primarily from the interest earnings on employee contributions to the unemployment trust fund during 1944 and 1945, and to the disability fund from May 21, 1945 to November 30, 1946.[49] If a deficit is incurred in the

[48] J. W. Noel, *Eastern Underwriter*, February 16, 1951, p. 37.

[49] This arrangement has the effect of permitting voluntary plans, as well as the state plan, to benefit from the contributions of covered employees prior to commencement of benefit payments.

operation of this extended liability account, both the state fund and voluntary plans are assessed a prorata share of the deficit. The assessment is limited to 0.03 per cent of taxable wages in any one year, but any deficit is carried forward to the next year.

There has been criticism of the financing of this extended liability account. It has been held that the voluntary plans are not paying their share of costs attributed to the account. The 0.03 per cent assessment has been consistently grossly inadequate, which has meant that the state fund pays the deficit. For example, in 1950, interest credited to the account was $2.9 million, and benefits charged were $9.5 million, leaving a current deficit of $6.6 million. The maximum credit of 0.03 per cent of taxable wages was $2.0 million, levied almost equally upon the state fund and voluntary plans. Consequently, the deficit for 1950 was $4.6 million.[50] This deficit has more often been between one and two million dollars annually.

Some industry representatives are concerned about this consistent deficit. They believe that neglect of the problem may result in a "scandal" which would adversely affect the insurance industry. Others of the same group point out that since the industry as a whole is losing money on compulsory disability insurance in California, it deserves the financial subsidy. They further rationalize this position by claiming that the state fund also has received contributions for which it pays few benefits, since some employers have wage-continuation programs which reduce the amount of disability benefit received by their employees. This is justifying one inequity by citing another, and, as they fully realize, does not solve the central problem.

In New Jersey, an "unemployment disability account" has been established which is similar to California's account. It also is financed primarily out of interest earnings on employee contributions transferred from the Unemployment Trust Fund. If a deficit arises, private plans and the state plan are assessed up to 0.02 per cent of taxable wages. The deficit problem of California has not arisen in New Jersey, due to a slightly higher rate of return on

[50] U.S. Department of Labor, *California Disability Insurance Program*, March, 1952, p. 44.

the New Jersey fund, a lower benefit schedule, and relatively fewer disabled-unemployed claimants.[51]

The New York plan provides that the employer continue to be liable for disability originating within four weeks after employment terminates. A Special Fund, administered by the Workmen's Compensation Board, has been established to pay benefits to those who become disabled after being unemployed for more than four weeks. The Special Fund was initially financed by a contribution of 0.2 per cent of the first $3,000 of wages, shared equally by employers and employees, during the period from January 1, 1950 to June 30, 1950. The fund is currently maintained by assessments levied on employers and carriers whenever the net assets of the fund go below a statutory minimum. An assessment of a little more than 0.05 per cent of taxable payroll was levied in 1951. The next assessment, 0.012 per cent of payroll, was not made until 1955. The Insurance Commissioner has required the companies to set up a reserve for potential assessment contributions to the Special Fund. This reserve was accumulated at the rate of 0.10 per cent of taxable payroll for the first eighteen months of the program. For the following three the rate was gradually reduced, and then, in 1955, raised to approximately 0.03 per cent. Some companies have several million dollars in this reserve.[52]

Some believe that the disabled-unemployed hazard should be covered by the unemployment compensation program, since the worker has no job. Six states that do not have disability insurance programs for employed workers permit an unemployed worker, who becomes disabled after filing an unemployment compensation claim and registering for work, to draw unemployment compensation so long as no otherwise suitable job is offered him. It has been pointed out, however, that these "Maryland amendments" only partially solve the problem, because under these laws

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[51] New Jersey Division of Employment Security, *17th Annual Report* (1953), Table 10; and California Department of Employment, *Report 1031A #4*, August 7, 1953, Table 9.

[52] See Chapter 9 for later developments in relation to this reserve.

if the disabled-unemployed worker is offered a suitable job and is unable to accept because of the disability, his unemployment benefits cease.[53] He then is left without income just when his needs are increased by medical expenses.

On the other hand, it is contended that the disabled-unemployed hazard is one for which temporary disability insurance is properly designed. A disability insurance program that protects workers only so long as they are in covered employment excludes a large part of the covered labor force. Even in prosperous times, many workers experience involuntary unemployment; in some occupations, such as construction work, intermittent employment is the normal pattern. The need for protection against disability is no greater for the employed worker who breaks his arm than it is for the unemployed worker who suffers a similar accident, and as a consequence is prevented from looking for work, and may be denied unemployment compensation.

A solution to this problem[54] would be achieved, (1) by passage of "Maryland amendments" permitting payment of unemployment compensation benefits to persons disabled while unemployed so long as no suitable work is offered; (2) by providing that after suitable work is offered, the disabled-unemployed worker is eligible for benefits under the disability insurance program. This solution would seem to apportion the costs of disability among unemployed workers more equitably between the unemployment compensation and the disability insurance programs.

Legislative trends in this area are difficult to predict. Much

[53] The criteria used to determine suitability of work are typically, "the degree of risk involved to his health, safety, and morals, his physical fitness and prior training, his experience and prior earnings, his length of unemployment and prospects for securing local work in his customary occupation, and the distance of the available work from his residence." While it may be questioned whether any work is "suitable" while the claimant is disabled, disability on the part of the claimant does not disqualify a job from being "suitable."

[54] The magnitude of this problem may be judged from the 1953 experience in New Jersey. Total benefits paid by the unemployment compensation program were approximately $60 million; total benefits paid by the disability insurance program, including benefits to the disabled unemployed were approximately $8.7 million; benefits paid to the disabled unemployed were approximately $1 million.

will depend upon the experience of the different programs during periods of considerable unemployment. It would be to the advantage of the disability insurance programs, and it would seem equitable, to shift part of the responsibility for the disabled unemployed to the unemployment compensation program.

CHAPTER • 9

Financial Problems

How much the disability program will cost, and how best to finance this cost are important questions for which answers must be found. These questions confront those considering new legislation as well as administrators of established plans. This chapter will discuss some of the problems that have arisen in relation to these questions. The financial experience of the state funds, and the insurance carriers writing temporary disability insurance, will be analyzed.

DISABILITY PLAN COSTS

The chief cost components of a disability insurance program are benefit costs and administrative costs. The former is by far the more important. Administrative costs, discussed at length in Chapter 10, will be mentioned briefly here.

Benefit Cost Factors

Benefit costs may vary significantly from program to program. In fact, within one program these costs will vary from season to season, and from year to year. Since a great variety of factors affect benefit costs, this discussion must limit itself to some of the more important problems.

The frequency and severity of disability experienced by insured workers account for the greatest proportion of benefit cost. These, in turn, are affected by such factors as the composition of the covered population in terms of sex, marital status, age, income level, and occupation. These are the factors given greatest con-

sideration by insurance companies in determining group disability premiums. Most companies consider the sex composition of the group as the element of greatest importance. One company, however, has compiled data which indicate that age is a more important factor than sex.[1] Since this insurance provides protection against nonoccupational disability, the occupation of the workers is usually not significant. Only those groups subject to an exceptional health hazard are rated. This extra premium is charged because of the difficulty in determining whether or not a disease is of occupational origin. Consequently, many claims are made against the insurer of the nonoccupational health hazard for disability which is due primarily to working conditions.

With a given rate of disability, benefit costs depend also upon the statutory provisions of the plan. Among the important provisions are the definition of disability, particularly in relation to pregnancy, level of benefits, length of waiting period, duration of benefits, benefit provisions for the unemployed, provisions regarding other income, disqualifications, and the base period.[2] The level of economic activity in the state is also important. Wage levels and volume of unemployment (significant cost factors in a disability program) are dependent upon general economic conditions.

Administrative Cost Factors

Administrative costs are also dependent upon program provisions. If contracting out is permitted, administrative expenses are sure to be higher than with a monopolistic state fund. Some of these added costs may be assessed against the voluntary plans. Certain other program provisions, such as coverage requirements, may affect administrative costs. The degree to which the disability program is co-ordinated with unemployment compensation will have a considerable effect upon the administrative costs borne by the state. The geography of the state and the size of the covered

[1] Confidential data compiled by this company show that the older age groups of both sexes have much higher rates of disability than those in the lower ages. Old men have higher rates than young women. In certain age groups women are even better risks than men.

[2] These factors have been discussed in Chapter 8.

population are also important considerations. These factors will be discussed more fully in the next chapter.

SOURCE OF FUNDS

The possibility of using unemployment compensation contributions, which are payroll-tax financed, for disability benefits has been proposed. Whether funds to finance a disability plan should be derived from a tax on payrolls or from general revenue has been discussed. Most discussion concerning source of funds, however, has had to do with the shares employees and employers should contribute toward nonoccupational disability benefits.

Financing Disability Benefits from Unemployment Compensation Funds

At times, labor has said that there is no need to impose new taxes in order to finance disability benefits. Elimination or revision of experience rating in unemployment compensation, it has said, will provide adequate funds for both programs. Labor was particularly vocal on this point during consideration of the New York bill.[3]

It was pointed out at that time that a tax of 3 per cent has proved to be in excess of unemployment compensation needs.[4] Experience rating was then introduced, which resulted in employer savings of $430,000,000 during the four years preceding enactment of the New York Disability Benefits Law. In 1948, the year before this law was passed, even though the effective tax rate for unemployment compensation was only 1.37 per cent, the Unemployment Insurance Trust Fund exceeded $1 billion. In 1953 the effective rate was approximately 1.5 per cent and the Fund again exceeded $1 billion.[5] Since disability benefits plus

[3] David Kaplan, "Attitude of Organized Labor Toward Sickness Disability Insurance," *Archives of Industrial Hygiene and Occupational Medicine*, December, 1950, p. 672.

[4] See "Federal Activity," Chapter 4.

[5] From annual reports of the State Advisory Council on Employment and Unemployment Insurance for New York State.

expenses totaled little more than $150 million for the years 1951 and 1952,[6] it is evident that these benefits could easily have been financed from unemployment compensation funds.

This method of financing disability benefits is used by the railroad program. Amendments in 1946 to the Railroad Unemployment Insurance Act added provisions for the payment of cash benefits during temporary disability. This program is financed solely by employer contributions. Since 1948, the balance in the Fund has been such that contributions have been limited to 0.5 per cent of taxable payrolls. While the total of disability and unemployment benefits has exceeded contributions in recent years, the combined benefits could have been financed by contributions of 1 per cent of taxable payrolls, plus interest on the Fund.[7]

The evidence[8] indicates that most states could finance both disability benefits and unemployment benefits during periods of high employment with a payroll tax of 3 per cent or less. This conclusion, of course, is entirely apart from the question of whether these programs should be combined or whether disability benefits should be financed by employers alone.

Payroll versus General Revenue Tax

Social insurance programs are often financed, at least in part, by governmental contributions derived from general revenues. This is more common in Europe than in the United States. The principal argument in favor of governmental contributions to a disability plan is the expectation that the general welfare will be improved by such a program. The general health of the population should improve, indigency should decrease, and there should be a stabilizing effect upon the economy. While a contribution derived from general revenues will tax many who are not eligible

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[6] New York Workmen's Compensation Board, *1953 Annual Report*, p. 31.

[7] Annual reports of the Railroad Retirement Board.

[8] During 1951, 1952, and 1953 no more than five states had an average employer contribution to unemployment compensation in excess of 2 per cent. The average employer contribution for all states during these years was 1.58, 1.45, and 1.35 per cent respectively. Therefore, most states could add 1 per cent to the unemployment compensation rate to pay for disability benefits and still charge a rate of less than 3 per cent. Data from U.S. Department of Labor, *The Labor Market and Employment Security*, September, 1954, p. 27.

for benefits, it may, to some extent, relieve the government of other payments such as public assistance.

Broadening of disability insurance coverage should be facilitated by such financing. When all wage earners contribute to such a program through general taxes, they are all entitled to benefits. With funds made available by governmental contributions, more liberal benefits could be granted than if financing were limited to contributions by employers and employees. General revenue taxation is usually less regressive than a payroll tax. This is especially true of general revenues levied in the form of income taxes.[9] If benefit schedules are to favor low-income groups, as some deem desirable, governmental assistance would provide more equitable financing of such a principle.

As long as disability insurance is provided under state legislation, it will continue to be financed most likely by a tax on payrolls. Most states, already faced with revenue problems, would give a cool reception to any proposals that added financial burdens. Federalization of disability insurance, on the other hand, could well lead to financing in part by a general revenue tax. Increasingly popular in Europe, this method of financing social insurance may gain advocates in this country.[10]

Employee versus Employer Financing

If the decision is reached to finance disability insurance, all or in part, by a tax on payroll, a further question arises as to whether this tax should be levied upon employees, employers, or both; and if levied upon both, what share should be paid by each.

Since this insurance pays benefits for disabilities that occur off the job, many believe that employees should pay the larger part of the cost. Even labor has often agreed with this position. Labor

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[9] Seymour Harris, *Economics of Social Security* (New York: McGraw-Hill Book Co., Inc., 1941), chaps. 2 and 3.

[10] Wilbur J. Cohen, "New Developments in Employee Disability," *Journal of the American Association of University Teachers of Insurance*, March, 1950, p. 38; Harry Becker, "Recent Developments in Employee Disability Programs," *Journal of the American Association of University Teachers of Insurance*, March, 1950, p. 45.

has preferred, on occasion, to pay all the costs because such an arrangement presumably enables labor to have a major voice in the operation of the program.[11] Exclusive control by one group, however, can lead to abuse.[12] Decisions as to the share to be borne by labor should be influenced by the fact that with few exceptions, labor cannot shift this tax, nor is it a deductible expense for the employee.

Employees benefit most directly from disability insurance benefits; nevertheless, employers also benefit considerably. Employers may gain from the improvement in health and security of their workers, from reduced turnover, and indirectly from the maintenance of purchasing power that results from a statewide disability program. Employer realization of these gains is attested to, in part, by the large number of voluntary disability plans contributed to, or financed entirely, by employees. Employer contributions have been justified also because it gives the employer a financial stake in the administration of the program. Employers "soon find out who pays the bill in some of the states where they thought 'I have no interest in this—it is just a tax on the employee!' If a loosely drawn law is enacted with overlapping benefits, the employer soon finds he is paying the bill, either directly or indirectly, in increased labor turnover, absenteeism and malingering. To keep the system sound, therefore, the employer should have a direct financial responsibility."[13] Most employer groups agree with this position. Some employer spokesmen have justified their contribution even on ideological grounds. They have said that if employers do not contribute, "their role will be

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[11] The California legislation requires a contribution from employees alone. The dominant labor group in the state does not want this changed. It believes that its legislative influence would be adversely affected by an employer contribution. Interview with Charles Scully, attorney for the California State Federation of Labor.

[12] It is believed that the many problems encountered by the Rhode Island plan can be attributed largely to the fact that labor has too dominant a voice in determining program policy. Since there is no employer contribution nor are commercial carriers permitted to write statutory benefits, there is little opportunity for employer groups or the insurance industry to counter labor influence. This absence of checks and balances, it is alleged, has led to abuse.

[13] W. Robert Bull, "What Type of Law Is Best from Industry's Standpoint," *Conference Board Management Record*, June, 1949, p. 281.

substituted either by the labor unions or by the government."[14] The commercial insurer feels strongly that an employer contribution is necessary for a well administered plan. This belief is expressed at times by a refusal to write a plan in which the employer is not directly interested financially.

Employers in nearly all states finance the whole cost of both workmen's compensation and unemployment compensation, as well as half the cost of Federal Old-Age and Survivors Insurance benefits. Because of these contributions, as well as for the reasons cited that justify an employee share in the cost, it is generally agreed that employers should not pay all the cost of temporary disability benefits. The proportion that employers should pay is influenced by the following factors; the relative ability of the employer to shift his share to the consuming public, the ability of the employer to deduct contributions, and the fact that the statutory contribution substitutes for an employer contribution to voluntary employee welfare plans.

A reasonable conclusion is that an equal contribution by employees and employers is equitable. Although this method of sharing the cost falls more heavily on employees, it is justified since they stand to gain most.

Drafters of the New York program began with this premise. The law provides that employees contribute 0.5 per cent of taxable payroll;[15] the balance necessary to meet these costs is paid by employers—that is, one-half the total, on the assumption that the costs of the program would approximate 1 per cent of taxable payroll. Actual experience during the first few years of operations has proved these estimates to be grossly conservative.[16] The re-

[14] Albert Pike, "Developments in State Disability Laws," *Conference Board Management Record*, June, 1949, p. 246.

[15] These are maximum amounts which employees are required to contribute. In many cases, the employer pays the entire cost of the plan. As a consequence, some 35 per cent of all covered employees make no contribution. See New York Workmen's Compensation Board *Annual Reports*.

[16] Reasons given for this error are: it takes time for covered employees to become sufficiently familiar with the law before they exercise their full rights; the insurance companies have been able to administer plans for small employers more economically than expected; and probably most important, many employers have maintained wage-continuation programs which make their employees ineligible for cash disability benefits.

sult in New York has been that employees have paid the major part of the cost, since they are obligated to pay 0.5 per cent of payroll. This has given rise to considerable criticism by labor. It is expected, however, that recent statutory benefit increases as well as the increased awareness by employees of benefit possibilities will increase claim costs, and thus raise rates and tend to bring about the equal sharing originally intended.

New Jersey provides also for contributions by both employees and employers. The bill originally called for an employee contribution of 0.75 per cent of taxable wages,[17] with a 0.25 per cent contribution by employers, subject to merit rating. Favorable experience resulted, in 1953, in a reduction of the employee contribution to 0.5 per cent. The employer's share was not changed. In many private plans, the employer pays the entire cost.

In California and Rhode Island, employees bear the entire financial burden of the disability program. In both instances, employee contributions to unemployment compensation were diverted to finance disability benefits at the time of the inauguration of the disability program. California has always levied a tax of 1 per cent of payroll for temporary disability insurance benefits. Very favorable claim experience during the early years of the plan enabled the California State Fund to amass a large reserve. Rhode Island initially diverted 1 per cent of a 1.5 per cent unemployment compensation contribution by the employee to its disability program; 0.5 per cent was continued for unemployment compensation. Very unfavorable experience necessitated the full 1.5 per cent being made available for disability benefits beginning July, 1946. The 1 per cent contribution was restored one year later when federal legislation[18] made available for disability benefits $28 million which had accumulated from prior employee contributions to unemployment compensation. There are no employee contributions in the railroad plan. Disability benefits are financed out of the unemployment compensation fund, which in turn is financed by an employer-financed tax on payrolls. These benefits

[17] This was not a new tax imposed upon the employees. It was a diversion of an employee contribution to unemployment compensation. See Chapter 4.

[18] See Chapter 4.

to date have cost approximately 0.5 per cent of taxable wages.[19]

Employee contributions to unemployment compensation greatly influenced the decision to finance in the same way the first three state disability plans. Since Alabama is the only state currently requiring such an unemployment compensation contribution, future legislation will not be influenced by this factor. For this reason, it is probable that an equal sharing of costs by employees and employers will be provided in future state disability plans.

FINANCING EMPLOYER CONTRIBUTIONS

If it is determined that employers should contribute to the disability program, another aspect of the financing problem is raised. Should their contributions be a uniform percentage of payroll, or should the cost to each group vary commensurate with the underlying risk? This problem does not arise in an employee-pay-all program. Labor prefers the uniform tax principle; furthermore, it is not administratively feasible to have variable employee tax rates. Political considerations may determine the financing method used. If the legislature, for example, prefers a privately insured, employer-liability type law, the uniform-tax method is almost precluded. If there is to be a state fund, however, this problem will be faced. This is true, since private insurers usually charge a premium commensurate with risk, whereas state funds often charge a uniform premium.

While it is possible to vary rates by industry, variable contribution rates are usually achieved by the use of merit rating. Merit rating, sometimes called experience rating, is a system of rate modification whereby rewards in the form of lower rates are granted for experience better than the average, and penalties or higher rates are levied for experience worse than the average.[20]

Uses of Merit Rating

Merit rating has been used to accomplish several purposes. One of the stated purposes has been to correct rate inequities. These

[19] Annual Reports of the Railroad Retirement Board.

[20] An exception is the merit-rating method used in most unemployment compensation programs. See below.

inequities have stemmed from the practice of charging uniform premiums although loss experience varies. Probably of greater importance has been the competitive purpose. Merit rating has given stock companies a means of competing more successfully with mutual companies for the large, preferred accounts. It has been used also to "compete" with self-insurance. Finally, in workmen's compensation it has served as a device to stimulate the reduction of hazard. Employers are encouraged to take steps that will reduce the chance of loss from certain hazards. Guards can be put upon machinery, stairway lighting can be improved, and similar steps can be taken to provide safer working conditions.[21]

Merit rating has been suggested for use with unemployment compensation plans to encourage stability of employment. The reasoning, contested by many, is that the individual employer can do much to reduce unemployment and should be encouraged, therefore, in such efforts by granting him a reduction in his unemployment compensation rates for a good employment record. A more justifiable use of merit rating in unemployment compensation, however, is for the purpose of restricting the size of the fund.

Two basic types of experience rating may be used in unemployment compensation: one, statewide rate changes are made depending on the size of the fund without reference to individual employer experience; two, the individual employer's taxes are related to benefits paid to his workers, without reference to the size of the fund. Many variations of the latter are used alone and several states combine the two types. But since the federal law practically prohibits use of the first type of experience rating, in refusing to grant tax-offset credit, it is not used alone.

While it is generally conceded that merit rating (type number two) served its intended purpose in encouraging preventive efforts during the early years of its use with workmen's compensation, it is questionable whether the device has any place in unemployment compensation or temporary disability insurance. Industrial accidents are attributable, in part, to inefficient plant

[21] See C. A. Kulp, *Casualty Insurance* (New York: Ronald Press Co., 1956), chap. 18, for a more elaborate discussion of merit rating.

management and can be corrected within the plant; unemployment primarily is a market phenomenon beyond influence by individual management, and the employer can do little to reduce the off-the-job hazard of temporary disability. Furthermore, the principle of social insurance is the pooling of good and bad risks for the mutual aid of all. Good risks, those with high incomes or low loss ratios, aid those with lower incomes or greater losses. This pooling scheme enables the program to provide the desired protection to those who have the greatest need and who, at the same time, are able to afford it least.

Arguments of Those Who Favor Merit Rating

Proponents of merit rating in disability insurance claim that it can be a factor in improving industrial hygiene and thus reducing disability.[22] Since a high rate of disability is reflected in high premiums, it will pay employers, they assert, to hire industrial physicians, equip infirmaries, and to take similar steps to keep the disability rate at a minimum. Little, if any, evidence is available to establish these claims. It is known, on the other hand, that effective administration is essential for a successful disability program. Merit rating does provide an incentive for proper administration (primarily claim administration) at the employer level.

To levy a uniform tax upon all firms despite their variable experience is inequitable from an economic point of view. Certain firms hire women and handicapped workers in order to lower wage costs. The resulting high rates of disability[23] should be considered as one of the costs of hiring these groups. These firms should pay higher disability premiums if they wish to utilize this type of labor.

The cost of disability varies from year to year, depending upon various factors, such as epidemics and the rate of unemployment.[24] A uniform tax rate, as commonly employed, will result in reserves building up in excess of needs in some years, while in

[22] Leonard J. Goldwater, "Sickness Disability Insurance Laws in Relation to Occupational Medicine," *Industrial Medicine and Surgery*, November, 1949, pp. 473–75.

[23] See Chapter 1.

[24] See Chapter 1.

other years the tax may not yield sufficient revenues to pay claims. During the surplus years there will be unwise political pressures to liberalize benefits, which are difficult to reduce in the lean periods.[25]

Arguments of Those Who Oppose Merit Rating

Opponents of merit rating question the effectiveness of this device in reducing disability. Many disabilities incurred while on the job are covered already by workmen's compensation. The disabilities covered by the temporary disability insurance program are more likely to be incurred off the job than on it, especially since most workers spend only about 40 hours, of the 168 hours in a week, on the job. This would indicate that there is little the employer can do, even if given a financial incentive, to reduce nonoccupational disability.

Employers can effectively administer disability insurance without the stimulus of merit rating. Furthermore, a financial incentive for a low claims record may result in discouraging valid claims as well as avoiding claims that are improper. It is difficult to determine the long-run economic effect of either policy. It is believed, however, that a uniform tax would not have a significant adverse economic effect. This belief stems from the fact that the tax on the employer is relatively small, and often the difference between a uniform and a variable tax for the firm would be small.[26]

The most frequently voiced objection to the use of merit rating in disability insurance is that it promotes discriminatory hiring practices. The most direct way in which employers can influence their nonoccupational disability is through selective hiring. Disability rates are determined to a great extent by such factors as age and sex. Thus merit rating may result in increased discrimination against the hiring of older workers, women, and those

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[25] Albert Pike, *Weekly Underwriter*, November 4, 1948, p. 1175.

[26] While a tax on employers of 0.5 per cent subject to experience rating might in a few cases vary from 0.25 per cent to 0.75 per cent (thus varying a maximum of 0.25 per cent from the average), the deviation, in most cases, would be much less. Information from Mr. Billedward Howland, Actuary for Mutual Benefit Health and Accident Association.

with chronic ailments. Members of these groups, though capable, frequently encounter difficulty in obtaining employment. Merit rating, in providing an additional financial incentive for their exclusion, would add to these difficulties. While it may be true that employers would not refuse to hire any worker solely because of the disability risk, this factor would be taken into account with others in forming hiring policies and practices.

State Merit Rating Provisions

California and Rhode Island levy a uniform tax with no merit rating. Commercial insurers and the state fund in New York charge a premium varying with the employer classification; in addition larger employers are eligible for experience rating. Labor has complained that the law in New York, which requires a uniform tax by employees while permitting the employer portion to vary, has resulted in labor paying too high a proportion of the total costs. A representative rate for a group with 25 per cent or fewer female employees is 62 cents per $100 of payroll—some large experience-rated cases have been charged as little as 50.6 cents. Of this the employee can be required to pay 50 cents, or practically all of the amount in some cases. This is in contrast to the equal sharing of costs which labor was given to understand would be the financial principle.[27]

Labor believes, furthermore, that discriminatory hiring practices and improper claim administration are promoted by such financing methods.[28] Specific cases of such practices are very few. But labor explains this by saying that it is very difficult to prove that a certain firm is engaging in discriminatory hiring. Insurance companies have received complaints from employees to the effect that employers require them to return to work before complete recovery. This practice is found among some small employers and stems, no doubt, from the need for the particular worker's skills and not from a desire to reduce claims.[29]

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[27] David Kaplan, "Attitude of Organized Labor Toward Sickness Disability Insurance," *Archives of Industrial Hygiene and Occupational Medicine*, December, 1950, p. 674.

[28] *Ibid.*, p. 674.

[29] From personal interviews with company officials.

New Jersey is the only state that provides for merit rating of contributions to the state fund; the merit rating applies only to contributions by employers. A separate account is maintained for each employer. The account is credited with the contributions of the employer and his employees, and is charged with all benefits paid to the disabled employed workers last employed by him. Employer rates vary according to a complicated formula which takes account both of the individual employer's record and the total amount in the fund. The basic employer rate is 0.25 per cent; this may be modified to a minimum of 0.1 per cent or to a maximum of 0.75 per cent. Workers continue to pay 0.5 per cent; their contributions are added to their respective employers' accounts.

To be eligible for a changed rate, which is computed as of July 1, an employer must have been covered continuously under the state plan for three years or more. Reduced rates first became effective July 1, 1951. Prior to 1953, only large employers were eligible for merit rating since it was necessary to have been credited with at least $1,500 in combined employer-employee contributions. In 1951, only about 1,500 of 26,000 employer accounts could be rated, principally because only that number had the required $1,500. Of these 1,500 rated employers, only 64 received penalty rates. Out of some 27,600 employer accounts processed for rating in 1952, only about 2,100 could be merit rated. Of the rated employers, 173 received penalty rates and the others received the minimum 0.1 per cent rate. Amendments in 1953 eliminated the $1,500-minimum-contribution requirement. No minimum contributions are now required to be eligible for merit rating. Of the 41,629 employers eligible for experience rating in 1955, approximately 24,000 received the minimum 0.1 per cent rate, while only 1,300 received various penalty rates.

Conclusion

The philosophical basis of social insurance—mutual aid—would seem to preclude the use of individual-employer merit rating in temporary disability insurance, despite its value for other types of insurance. This viewpoint is substantiated further by the potential encouragement of discriminatory hiring practices,

the complexity and added administrative costs, the slight effect upon the disability rate which may result, and the disputes over improper claim administration which may arise.[30] Particularly where employees pay a share of contributions, consideration should be given to the desires of labor that disability insurance be financed by a uniform tax. Nevertheless, the alternating surpluses and deficits, characteristic of uniform taxation, do present formidable problems.

It may be feasible to have everyone pay a uniform rate, but a rate subject to variation from year to year depending upon the size of the disability fund. Thus, if the fund exceeded a certain maximum figure, or ratio of benefits paid, contributions for the next year would be decreased automatically. Conversely, a low balance in the fund would result in an increase in the rate of contribution. This procedure would remove some of the major objections to uniform taxation, and at the same time it would provide the benefits of a uniform tax desired by labor.

Trends

The probable trends in the use of merit rating will be influenced largely by the relative strength of the political forces interested in disability insurance, which will determine the type of law passed. Passage of a law such as that in New York will, in all probability, provide for individual-employer merit rating. Passage of a law providing for a compulsory or competitive state fund may well provide some form of variable financing, since the accumulated reserves of the existing programs have been a source of considerable contention.

FINANCIAL EXPERIENCE OF STATE FUNDS

The financial experience of the state funds has varied enormously. In so short a period it is difficult to draw sound conclusions. Furthermore, the financial backlog created by federal

[30] While no satisfactory evidence of claim administration influenced by merit rating is available, some labor leaders believe that such is the case. The application of a uniform rate to all employers would eliminate grounds for such suspicions.

legislation for state disability benefits provided considerable sums that have nothing to do with extended financing.[31] This last factor has greatly influenced the financial policies of three of the funds. The financial development of the funds has led to many legislative amendments. An analysis of these developments is necessary for an understanding of the disability programs.

Rhode Island

Subsequent to passage of the law and prior to the time benefit payments began, in April, 1943, a fund of $2.7 million had accumulated. By the end of that year the balance was $3.4 million. However, for the year 1944, disbursements exceeded income by over one half million dollars. In 1945 the deficit amounted to $0.39 million, and for the first six months of 1946 the deficit was $0.51 million. By July 31, 1946 the fund had reached a low of $1.8 million. Insolvency, imminent because of extremely liberal benefit provisions, was prevented only because of funds collected prior to the payment of benefits.[32]

By 1946 it had become clear that drastic changes in the disability law were necessary to avoid financial collapse. Marked benefit reductions or a sizeable increase in contributions were alternatives open to the legislature. It chose to take steps in both directions. The most important change effected was an increase in the contribution rate from 1 per cent to 1.5 per cent. This change did not meet with the resistance that might have been expected. It will be recalled that prior to passage of the disability law, employees contributed 1.5 per cent of wages for unemployment compensation. Two thirds of this tax was then diverted to the disability fund, the other third retained for the unemployment fund. The 1946 amendments added this remaining 0.5 per cent to the disability fund, thus avoiding any additional contribution by employees. The increased contribution to the disability fund became effective July 1, 1946, and was to continue for two years.

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[31] See p. 51.

[32] Mimeographed statement by the Rhode Island Department of Employment Security, June 17, 1953; and New York Department of Labor, *Studies in Disability Insurance* (1949), Table I.

It was based upon the assumption that this period would be sufficient to accumulate adequate reserves. At the same time the legislature passed two amendments restricting benefit disbursements. The first of these restricted payments for pregnancy, and the second restricted duplication of disability benefits and workmen's compensation benefits.[33]

The effect these amendments would have had upon the fund cannot be known because of the subsequent passage of the Knowland Amendment by Congress late in 1946. This law provided that any state that had collected taxes from employees for unemployment insurance might transfer all such collections to the state disability insurance program. This act, which made nearly $29 million available for temporary disability insurance benefits, alleviated the financial emergency which prompted the 1946 amendment increasing the contribution rate.

Because of these funds, the rate of contribution was again reduced to 1 per cent, effective July 1, 1947.[34] Of the total funds made available by Congress, $15 million was withdrawn in 1947 and the remainder in 1948. Since the Knowland Amendment stipulated that the funds available were to be used for benefit payments only, with administrative costs to be otherwise provided, the Rhode Island legislature created two state funds. One, known as the Cash Sickness Compensation Fund, to which the federal funds were transferred, was established with the stipulation that benefit payments would be made from it. The other, known as the Cash Sickness Reserve Fund,[35] was created to receive the existing reserves and current collections from the 1 per cent tax. Administrative costs were paid from this second fund. It was provided that all benefit payments would be made from the Compensation Fund until it was exhausted. (One reason for this provision was that the legislature feared that any of the $29 mil-

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[33] See Chapter 8.

[34] This reduction resulted in a saving to employees, since they no longer contributed to unemployment compensation.

[35] On January 1, 1952 the title of the disability program was changed from Cash Sickness Compensation to Temporary Disability Insurance. At that time the funds became known as the Temporary Disability Insurance Fund and the Temporary Disability Insurance Reserve Fund respectively.

lion still unused would be subject to federal control. On the other hand, the funds collected by the state tax were subject only to control by the state legislature. It was reasoned, therefore, that the state's interests would be served best by paying out the federal funds first. These funds were exhausted in November, 1951.)[36]

Since 1947 the solvency of the disability program has been restored. At all times the reserve balance has been adequate to cover estimated total disbursements for approximately five years, even if further contributions to the fund should stop entirely. The fund has continued to increase each year since 1950 (see Table 5). Nevertheless, this does not mean that there is no financial problem. During four of the past seven years, benefit payments alone have exceeded contributions.[37]

Recent reports indicate that the financial situation is improving. The year 1953 was the first year since 1948 that contributions exceeded benefit expenditures. Benefits plus administrative costs, however, continue to exceed contributions. This improvement is attributed, in part, to recent tightening in the eligibility requirements, e.g., a claimant must now earn at least thirty times his benefit rate, rather than a minimum of $300, during his base period.[38]

The financial difficulties that beset the Rhode Island program have received a great deal of publicity, and have provided a field day for opponents of social insurance. The difficulties were due to serious shortcomings in the plan itself, particularly the provisions allowing benefits for pregnancy, for disabilities covered by workmen's compensation, and to persons not conclusively members of the labor force. The financial problem was compounded by the delay of the legislature in correcting these difficulties even after they were highlighted by disability insurance administrators. It should be remembered, however, that this was pioneer legislation. The mistakes made in Rhode Island have guided the plans

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[36] Rhode Island Department of Employment Security, *17th Annual Report* (1952), p. 28.

[37] The yearly increase in the fund despite this situation has been possible because of the interest received on the fund. This interest exceeded $790,000 in 1953.

[38] Rhode Island Department of Employment Security, *18th Annual Report* (1953), p. 30.

TABLE 5

RHODE ISLAND DISABILITY INSURANCE STATE FUND: SELECTED FINANCIAL DATA, 1943–55

Year	Net Contributions	Net Benefit Payments	Administrative Costs	Reserve Fund Balance December 31*
1942	$1,584,526		$ 1,592	$ 1,583,166
1943	4,672,442	$2,857,168	66,038	3,377,018
1944	4,572,383	5,034,675	130,110	2,789,691
1945	4,388,557	4,668,796	141,482	2,401,514
1946	4,896,537	4,606,211	153,543	2,581,108
1947	6,985,270	4,291,895	172,223	19,897,702†
1948	5,521,595	4,315,496	211,736	34,983,207†
1949	5,035,346	5,430,831	268,765	34,879,971
1950	5,373,510	6,313,064	293,948	34,093,319
1951	6,079,557	6,169,916	357,872	34,477,933
1952	5,940,408	6,222,153	334,155	34,721,643
1953	6,287,068	6,220,168	371,002	35,221,553
1954	5,730,603	5,918,141	373,917	35,504,310
1955	5,896,588	5,646,432	337,482	36,255,429

* Includes interest and withdrawals from Unemployment Trust Fund.

† Withdrawals of $15,000,000 and $13,968,681 respectively from the Federal Unemployment Trust Fund.

Source: Rhode Island Department of Employment Security, *Temporary Disability Insurance, Summary of Financial and Related Data*, mimeographed release (June 6, 1953), *Annual Reports*.

that followed. A series of amendments have served to correct many of the original faults. These amendments, in conjunction with the funds made available by the Knowland Amendment, have lessened the probability of insolvency. Notwithstanding the fact that contributions continue to be exceeded by benefit and administrative expenditures, the state fund, by virtue of the interest earned, is increasing annually.

California

Collection of contributions of 1 per cent of taxable payrolls from employees began on May 21, 1945 under the California Unemployment Compensation Disability Benefits Law. Since nearly all eligible workers contributed to the state fund during 1946, the reserve in the disability fund at the end of that year was almost $29 million. Passage of the Knowland Amendment per-

mitted commencement of benefit payments on December 1, 1946. (The funds transferred under this act, with interest, now exceed $120 million, and have been kept separate from the Disability Fund. While this entire Unemployment Trust Fund is available for benefit payments, only a token $200,000 has been transferred to the Disability Fund—"just to make sure that it could be done.")

Within the Disability Fund are an administration account and an extended liability account. Prior to 1952, 5 per cent of contributions were deposited in the administration account. Since that time the amount available for administration is whatever the State Director of Finance considers necessary. Administrative assessments collected from private plans are credited also to this account. The extended liability account is a device for allocating the cost of financing benefits to unemployed claimants between the state fund and private plans. Private plans are assessed a share of these benefit expenditures.[39]

As a consequence of increased private-plan operations, contributions to the state fund consistently decreased from 1947 to 1950. The peak in the number of private plans was reached in the latter part of 1951. Since then there has been considerable shifting of private plans to the state fund. This shifting, in conjunction with increased employment and higher wages, has resulted in substantial yearly increases in contributions to the state fund.

Table 6 indicates a consistent increase in benefit expenditures. This is a result of liberalizations of benefits plus the workers' increased awareness of the program. These factors, in conjunction with the decrease in contributions, have increased the ratio of benefit payments to contributions from 34 per cent in 1947, to 90 per cent in 1953. Administrative costs have paralleled the growth of benefit expenditures.[40] The annual surplus of contributions over benefit and administrative expenditures has continued to decline. It is possible that the present benefit scales in California are approximately the maximum that a 1 per cent contribution will support, on a current basis.

The Disability Fund, exclusive of the amounts available in the

[39] See Chapter 8.
[40] See Chapter 10.

Unemployment Trust Fund, has also consistently increased, although at a decreasing rate. The fund built up from current contributions is now sufficient to pay benefits at the present rate for almost three years, even if further contributions were to cease. This fund, backed by a comparable sum available in the Unemployment Trust Fund, assures solvency in the immediate future, at least.

TABLE 6

California Disability Insurance State Fund: Selected Financial Data, 1948–55
(Add 000)

Year	*Net Contributions*	*Total Benefits*	*Administrative Costs**	*Disability Fund*	*Unemployment Trust Fund*
1946	$29,005	$ 154	$ 228	$ 28,823	$104,463
1947	51,512	17,732	1,788	61,020	106,509
1948	46,255	21,956	2,147	84,030	108,673
1949	36,587	23,152	2,508	96,069	110,895
1950	33,105	26,321	2,178	103,998	112,794
1951	34,147	24,330	2,591	115,785	115,349
1952	36,368	29,363	3,033	125,087	117,652
1953	40,110	32,370	3,214	133,659	120,074
1954	43,775	42,958	3,231	135,989	122,553
1955	47,915	44,299	3,401	141,619	124,864

* Includes state costs of administering private plans.

Source: California Department of Employment, *Report 1009 #13*, February 14, 1956.

New Jersey

The Temporary Disability Benefits Law approved by the legislature on June 1, 1948 provided that employee contributions of 0.75 per cent of wages would commence immediately, with employer contributions of 0.25 per cent, and benefits to begin on January 1, 1949. Provisions were also made to transfer $50 million to the disability fund from the Federal Unemployment Trust Fund, as permitted by the Knowland Amendment. This transfer, in conjunction with employee contributions, provided a fund balance of over $26 million prior to the payment of any benefits.

Three separate accounts are set up within the state disability benefits fund: an administration account, an unemployment

disability account, and an individual-employer disability benefits account for experience rating. The administration account is credited with 0.08 per cent of the wages taxed by the state plan plus all receipts from the administrative assessment levied against private plans. This administrative assessment is prorated among private plans in proportion to wages covered, to cover the costs of supervisory administration by the program officials. From this account are paid all costs of administering the disability program, including the costs of supervising private plans. The unemployment disability account is the account from which all benefits to disabled unemployed workers are paid. This account is described in Chapter 8. The individual-employer disability benefits account is set up to facilitate experience rating.

As shown in Table 7, contributions to the state fund have decreased nearly every year since the program started. This has been due primarily to the continued transfer of employers from the state plan to private plans. The sharp decrease in contributions for 1953 resulted from the reduction in employee contributions to 0.5 per cent effective January 1, 1953. There has been a parallel

TABLE 7

NEW JERSEY DISABILITY INSURANCE STATE FUND: SELECTED FINANCIAL DATA, 1948–55

(Add 000)

Year	*Net Contributions*	*Total Benefits*	*Benefits Paid*		*Administrative Costs**	*Fund Balance December 31†*
			Employed Workers	*Unemployed Workers*		
1948	$17,739		$2,761		$ 370	$62,308
1949	10,422	$3,365	2,761	$ 657	970	72,373
1950	9,588	4,913	3,903	1,100	1,057	78,394
1951	9,296	5,390	4,436	953	990	84,071
1952	9,701	6,186	4,933	1,253	1,053	88,970
1953	8,611	8,578	7,604	974	1,184	90,505
1954	9,076	8,959	7,811	1,148	1,204	92,127
1955	9,610	9,474	8,474	1,047	1,229	94,123

* Includes state costs of administering private plans.

† In addition to net contributions, income includes withdrawal of $50,000,000 from Unemployment Trust Fund, private plan assessments, state plan experience rating assessment, fines, interest, and other income.

Sources: New Jersey Department of Labor and Industry, *Annual Employment Security Reports.*

increase in benefit expenditures, due mainly to statutory liberalizations of benefit allowances, and partly to an increase in utilization of benefits as employees have become more familiar with program provisions. Aggregate benefits to unemployed workers have fluctuated to some degree, but the trend has remained fairly constant since 1950. Aggregate benefits to employed workers increased gradually from 1950 through 1952. Then in 1953 these benefits showed a very sharp increase of 55 per cent over 1952. This substantial increase resulted from several causes, some of which are expected to continue in future years. (A mild epidemic of respiratory infections in January and February of 1953 accounted for a small part of the increase.) The major part of the increase in benefit payments resulted directly from changes in the law increasing the maximum weekly benefit amount from $26 to $30, which became effective July 1, 1952. Changes effective January 1, 1953 increased the percentage of average weekly wage paid from approximately 59 per cent to 66.66 per cent.[41]

The fund balance has increased yearly from $62.3 million at the end of 1948 to $94.1 million at the end of 1955. This balance increased $2.5 million during 1955, notwithstanding the fact that benefits alone almost equaled tax contributions. The increase is attributable to interest earnings on the fund. The very large fund balance in relation to benefit expenditures assures that the solvency of the state fund is not an immediate issue. The relationship between benefits and contributions, on the other hand, would indicate that benefit levels cannot be increased very much if the current contribution rate is continued, unless withdrawals are made from the fund.

New York

State Insurance Fund. The State Fund in New York differs markedly from the other state funds in method of operation and in relative importance as well. The State Insurance Fund, originally created by the Workmen's Compensation Act in 1913, limited its operation to workmen's compensation until 1950. When the Disability Benefits Law was passed, provision was made for

[41] New Jersey Division of Employment Security, *17th Annual Report* (1953), p. 39.

the Fund to write temporary disability insurance together with workmen's compensation. The Fund, located within the Department of Labor, is administered by eight commissioners appointed by the governor. In contrast to the other state disability plans, the State Fund does not provide automatic coverage. Consequently, the Fund must compete with commercial carriers for business. The Fund does not employ sales representatives. It does have, however, an educational bureau, which competitors maintain is a sales agency.

The Fund operates very much as a commercial carrier. The Workmen's Compensation Board (the agency administering the Disability Benefits Law) exercises no more control over the Fund than it does over the commercial carriers writing disability benefits. The Fund must meet the same filing requirements and approval of policy forms as do the private carriers. Premium rates vary both by classification (type of industry and number of female workers) and by individual employer. Premium taxes are paid on the same basis as commercial carriers. The primary operational difference between the Fund and the commercial carriers is that the former must insure all who apply for coverage.[42] Since variable rates are charged, there is little problem of adverse selection against the Fund.

Although the Fund writes approximately 25 per cent of the workmen's compensation in the state, it writes only about 3 per cent of the temporary disability insurance. The Fund has approximately 15,000 DBL policyholders. A good many of these have as few as one or two members in the group insured with the Fund.[43] This large number of small groups has necessitated the

[42] Other operational differences are that the Fund is limited to 25 per cent of premiums for expenses (actual expenses for 1952 were half what the law permitted); and though permitted to write benefits in excess of statutory minima, it has not done so.

[43] The law requires that only employers of four or more employees must have disability insurance. However, many small employers subject to the law have part of their employees covered under industry-wide insurance contracts sponsored by a union. For example, a trucking firm may have two secretaries and five drivers, thus subjecting it to the law. The five drivers may be covered by a union insurance contract, leaving the two secretaries in need of coverage. Insurance companies are reluctant to insure as few as two; consequently many such groups are insured by the State Insurance Fund.

use of a simplified administrative procedure to minimize costs. All policies are written on a uniform annual basis, as of July 1. Employers are billed quarterly with a form that enables them to use wage information compiled for unemployment compensation purposes.[44] These procedures enable the Fund to limit total expenses to approximately 12.5 per cent of earned premiums.[45]

The relatively small number insured, approximately 150,000, has been obtained, notwithstanding the fact that the Fund has offered what is claimed to be the lowest rates.[46] This small number may be attributed to low sales activity, as well as to the fact that the Fund does not write benefits in excess of the statutory minima.

The premium volume during the past five years has fluctuated little. While the expense ratio has remained relatively constant, there has been an increase in the loss ratio each year. The sharp increase in the loss ratio in 1955 was caused primarily by one large group with which the Fund had very poor experience. Since that group is no longer insured with the Fund, the loss ratio has been lowered. The increased loss ratios have been offset, in part, by lower assessments for the unemployed.[47] This has contributed to the maintenance of relatively large contributions to surplus each year, except 1955 (see Table 8).

Special Fund. There is another fund paying disability benefits in New York, operated by the state, which has some attributes of a state fund. It is the Special Fund, created by the Disability Benefits law for the purpose of paying benefits to disabled workers who have been unemployed for more than four weeks, and to employed claimants whose benefits are not paid by the responsible employer. This Fund is administered by the Workmen's Compensation Board. The Fund was initially financed by a contribution of 0.2 per cent of wages, assessed equally against employers and employees from January 1, to June 30, 1950. These contributions

[44] Some insurance companies use a similar procedure for small groups.

[45] Information furnished by the State Insurance Fund.

[46] While it is probably true that the Fund's rates for small groups are lower than those of commercial insurers, this may not be true for the large experience-rated risks.

[47] See p. 158.

TABLE 8

NEW YORK STATE DBL INSURANCE FUND: SELECTED FINANCIAL DATA, 1951–55

	1951		1952		1953		1954		1955	
	Amount	*Percentage of Premium Earned*	*Amount*	*Percentage of Premium Earned*	*Amount*	*Percentage of Premium Earned*	*Amount*	*Percentage of Premium Earned*	*Amount*	*Percentage of Premium Earned*
Premiums earned	$2,532,617	100.0	$2,343,211	100.0	$2,421,296	100.0	$2,396,440	100.0	$2,703,299	100.0
Losses incurred	813,618	32.1	856,834	36.5	1,052,614	43.5	1,168,155	48.7	1,842,640	68.1
Assessment for unemployed	319,562	12.6	292,179	12.5	195,094	8.1	15,592	.1	136,382	5.0
Total expenses	461,233	18.2	287,712	12.3	354,748	14.7	363,125	15.1	389,566	14.4
Dividends	518,083	20.4	334,619	15.0	321,359	13.2	354,033	14.7	367,955	13.6
Surplus	420,120	16.4	571,866	24.7	496,881	20.5	494,635	20.6	—33,244	—.1

Source: Information from the New York State Insurance Fund.

totaled more than $10 million. The law provides that if net assets of the Fund are $11 million or less, or $1 million less than twice the amount of benefits paid from the Fund during the preceding year, whichever is the greater, a special assessment is to be levied. The amount of the assessment will be that amount necessary to restore the Fund to $12 million or an amount equal to twice the sum of the benefits paid from the Fund in the preceding year, whichever is greater. The assessment is prorated among the carriers, State Insurance Fund, and self-insured employers in proportion to the payrolls covered by each. Emergency assessments are provided for in the event that net assets of the Fund shall be less than $3,000,000 and the disability claims currently being paid indicate the necessity of supplementing the assets of the Fund before the next annual assessment can be made.

Assessments for the first purpose were levied for the first time in 1951. The rate of assessment was slightly more than five cents for each $100 of payroll. The next assessment, 0.012 per cent of payroll, was not made until 1955. Benefits paid from this Special Fund have averaged a little more than $500,000 per year since its inauguration.

FINANCIAL EXPERIENCE OF INSURANCE COMPANIES

For the most part, temporary disability insurance has been profitable for insurance companies. There are, however, companies operating in each state which have had losses in this line. Moreover, California business has produced losses for all companies as a whole, in certain years. Company experience will be discussed by state. While California experience is that most fully reported, sufficient data have been obtained from all states to indicate that many of the problems experienced in that state are equally applicable to the others.

California

The companies first segregated the results of their temporary disability insurance business in 1949. All-company loss ratios in-

creased from 68.5 per cent in that year to 82.8 per cent in 1952, and then dropped to 78.3 per cent in 1955. During the six-year period, 1949 through 1954, loss ratios for individual companies varied from approximately 27 per cent to 207 per cent of earned premiums. Extremes of 23.2 to 97 per cent were reported in 1955. However, among the top ten companies in 1955, ranked by premiums written (each writing over $1 million in premiums), loss ratios only varied from 65.1 to 88.6 per cent.[48] The results of one study indicated that loss ratios of casualty companies in California are typically lower than those of life companies. No explanation of this phenomenon was given.[49]

In contrast to rising average loss ratios, all-company expense ratios have decreased continuously from 23 per cent in 1949 to 16.2 per cent in 1955. Much of this decrease is attributable to reductions in commission and other acquisition expenses. This item alone has fallen from 12 to 7.1 per cent in the seven-year period. The expense ratios of individual companies also have varied considerably. In 1955 expense ratios varied from 1.3 to 52.5 per cent. For the top ten companies this ratio ranged from 9.6 to 23 per cent in the same year.

In 1949 an average profit of 5.5 per cent on net premiums earned of $25,434,018 was produced. Each of the next three years, on the other hand, showed an underwriting loss. These losses were as much as 1.9 per cent of a rapidly increasing premium volume. Fortunately, a marked improvement was experienced in 1953 and 1955. The latter year produced a profit of 3.6 per cent of a still greater premium volume.

For individual companies, however, there were marked deviations from the all-industry average. In 1949, of thirty-nine companies writing temporary disability insurance, twelve showed losses. Losses ranged as high as 43 per cent of net premiums earned, while profits were as great as 32.6 per cent. Among the top ten companies the range was from losses of 4 per cent to

[48] Data for this section were obtained from an analysis of all company statements.

[49] John S. Bickley, *The Impact of a State Disability Act on Insurance Companies: A Study of the California Experience* (Columbus: The Ohio State University, Bureau of Business Research, 1954), p. 23.

TABLE 9

SUMMARY OF FINANCIAL EXPERIENCE OF INSURANCE COMPANIES WRITING DISABILITY INSURANCE IN CALIFORNIA, 1949–55*

(Add 000)

	1949		1950		1951		1952		1953		1954		1955	
	Amount	*Percentage of Premium Earned*	*Amount*	*Percentage of Premium Earned*	*Amount*	*Percentage of Premium Earned*	*Amount*	*Percentage of Premium Earned*	*Amount*	*Percentage of Premium Earned*	*Amount*	*Percentage of Premium Earned*	*Amount*	*Percentage of Premium Earned*
Net premiums earned	$25,434	100.0	$31,316	100.0	$39,853	100.0	$44,611	100.0	$47,087	100.0	$43,434	100.0	$45,314	100.0
Dividends	779	3.1	936	3.0	492	1.2	458	1.0	624	1.3	700	1.6	870	1.9
Losses incurred	17,410	68.5	24,506	78.3	32,322	81.1	36,934	82.8	37,223	79.1	35,839	82.5	35,469	78.3
Claims expenses	534	2.1	645	2.1	787	1.9	953	2.1	910	1.9	864	2.0	960	2.1
Commission and acquisition	3,059	12.0	3,300	10.5	3,538	8.9	3,646	8.2	3,638	7.7	3,270	7.5	3,448	7.1
General administration	1,139	4.5	1,145	3.6	1,304	3.3	1,398	3.1	1,393	2.9	1,337	3.1	1,326	3.0
Taxes	1,127	4.4	1,387	4.4	1,762	4.4	2,072	4.6	2,173	4.6	2,044	4.7	1,611	3.5
Total expenses	5,859	23.0	6,476	20.7	7,390	18.5	8,069	18.1	8,114	17.2	7,516	17.3	7,346	16.2
Surplus	1,386	5.5	—603	—1.9	—352	—.9	—850	—1.9	1,126	2.4	—620	—1.4	1,629	3.6

* Disability insurance data was not segregated prior to 1949.

Source: Company statements.

profits of 13.1 per cent. In 1955, sixteen of forty-nine companies produced losses or showed no gain.[50] The results for all companies in that year varied from losses of 22.2 per cent to profits of 63.3 per cent; among the top ten companies the variations ranged from losses of 11.6 per cent to profits of 12 per cent.

Life insurance companies write most of the temporary disability insurance in California. Of the fifty-one companies competing in California in 1955, thirty-one were life companies writing approximately 75 per cent of the premium volume. In that year, eight of the first ten companies were life insurance companies.

Expense ratios in this line typically are lower for life companies than they are for casualty insurers. A study made in California in 1951 indicated that the average expense ratio was 17.7 per cent for life companies whose operations produced a profit for that year, while with casualty companies showing a profit, expense ratios averaged 25.8 per cent.[51] This disparity is attributed, in part, to the different methods of paying commissions. Casualty companies generally pay a flat commission of approximately 7 per cent both initially and upon each renewal, whereas life companies generally pay a higher initial commission, with substantially lower renewal commissions.

New Jersey

Financial experience of companies operating in New Jersey has been generally similar to that encountered in California. Because the companies were not required to segregate New Jersey disability insurance experience prior to 1952, data are limited.[52] Average loss ratios, as shown in Table 10 have been somewhat lower than in California; average expense ratios are likewise lower. Smaller commission and acquisition costs, as well as lower taxes, account, at least in part, for the lower expense ratios in New Jersey. The savings in commission and acquisition costs have been

[50] Whether in each case these were real losses is questioned. Most of the companies reportedly have not made a thorough analysis of their temporary disability experience. If any have done so, such information has not been made available.

[51] John S. Bickley, *op. cit.*, p. 23.

[52] Most companies report they have not segregated temporary disability insurance experience from other group disability experience unless required to do so.

TABLE 10

SUMMARY OF FINANCIAL EXPERIENCE OF INSURANCE COMPANIES WRITING DISABILITY INSURANCE IN NEW JERSEY, 1952–55*

(Add 000)

	1952		1953		1954		1955	
	Amount	*Percentage of Premium Earned*	*Amount*	*Percentage of Premium Earned*	*Amount*	*Percentage of Premium Earned*	*Amount*	*Percentage of Premium Earned*
Net premiums earned	$24,191	100.0	$24,696	100.0	$23,022	100.0	$23,222	100.0
Dividends	842	3.4	912	3.7	938	4.1	1,028	4.4
Losses incurred	19,234	79.5	20,282	82.1	17,188	74.6	17,739	76.4
Claims expense	471	1.9	428	1.7	377	1.6	421	1.8
Commission and acquisition	1,424	5.9	1,332	5.3	1,176	5.1	1,133	4.9
General administration	945	3.9	954	3.8	908	3.9	822	3.5
Taxes	873	3.5	976	3.9	957	4.1	874	3.8
Total expenses	3,712	15.4	3,691	15.0	3,417	14.9	3,249	14.0
Surplus	402	1.7	188	0.7	1,480	6.4	1,206	5.2

* Companies were not required to report prior to 1952.

Source: Mimeographed reports from New Jersey Division of Employment Security.

attributed, by one company official, to the absence of excessive competition in that state.

While many companies have experienced losses with their New Jersey writings, several of the companies with large premium volume there have made profits as high as 10 and 17 per cent of premiums earned.[53] As in California, there is a tendency for the casualty companies to have lower loss ratios and higher expense ratios than the life companies.

New York

New York has been the most profitable state for disability insurance. Average profits have increased annually from 3.7 per cent for the first six months of operations during 1950 to as high as 12.8 per cent for 1954. The relatively low rate of profit in 1950 was due to large initial expenses.

Average loss ratios have been comparatively low—as low as 55 per cent for 1950, and only 70.3 per cent for the peak year of 1955. In addition to the losses incurred, however, the companies have been setting aside assessment reserves for benefits to unemployed disability claimants. These assessment reserves are to be drawn upon in the event that it becomes necessary for the Workmen's Compensation Board to levy assessments for payments to be made from the Special Fund. Since these reserves have been large, accumulating at the rate of 11 and 12 per cent of earned premiums in some years, they have been subject to criticism as being excessive.

In April, 1954, the Hotel Trades Council filed suit in the New York Supreme Court against 18 insurance companies for recovery of $22 million which the companies had allotted to these reserves. It was alleged that the reserves represented excessive premiums which should be returned.[54] The companies contended that these reserves fulfill a requirement set by the Superintendent of Insurance, and represent reserves against a contingent liability. While admittedly large, these reserves, it is argued, may well be inadequate in the event of a period of widespread and sustained

[53] Data from an analysis of selected company reports.
[54] *The Weekly Underwriter*, May 8, 1954, p. 1172.

TABLE 11

SUMMARY OF FINANCIAL EXPERIENCE OF INSURANCE COMPANIES WRITING DISABILITY INSURANCE IN NEW YORK, 1950–55

(Add 000)

	1950*		1951		1952		1953		1954		1955	
	Amount	*Percentage of Premium Earned*	*Amount*	*Percentage of Premium Earned*	*Amount*	*Percentage of Premium Earned*	*Amount*	*Percentage of Premium Earned*	*Amount*	*Percentage of Premium Earned*	*Amount*	*Percentage of Premium Earned*
Premiums earned	$32,226	100.0	$74,126	100.0	$77,905	100.0	$81,771	100.0	$77,405	100.0	$79,851	100.0
Losses incurred	17,723	55.0	44,978	60.7	49,080	63.0	54,335	66.4	53,004	68.5	56,157	70.3
Assessment for unemployed	3,741	11.6	9,007	12.1	8,658	11.1	5,346	6.5	805	1.0	1,316	1.7
Commission and acquisition	4,065	12.6	6,713	9.1	5,957	7.6	5,838	7.1	5,661	7.3	5,381	6.8
Taxes	804	2.5	1,772	2.4	1,798	2.3	1,959	2.4	1,925	2.5	1,940	2.4
Other expenses	2,743	8.5	5,135	6.9	5,180	6.7	5,278	6.5	4,921	6.4	4,874	6.1
Total expenses	9,578	29.7	14,677	19.8	13,690	17.6	14,268	17.5	13,656	17.7	13,477	16.9
Surplus	1,184	3.7	5,466	7.4	6,477	8.3	7,822	9.6	9,940	12.8	8,901	11.1

* For period July 1, 1950 to December 31, 1950.

Source: Reports from New York Insurance Department.

unemployment. The Supreme Court of the state granted the defendants' motion to dismiss the complaint. In June 1954, the Superintendent considerably reduced this reserve requirement.

Increasing loss ratios, resulting in part from increases in statutory benefits, have been offset somewhat by steadily decreasing expense ratios. From an initially high level of 29.7 per cent in 1950, the average expense ratio was reduced to 17.7 per cent in 1955. This ratio is now in line with that of other states.[55]

Generally, New York DBL writings have been profitable; there have been exceptions, however. Many companies experienced losses during 1950, which were attributed to the expenses incurred in getting the program started in New York. As in the other two states, individual company experience has varied widely from the average. There have been great differences even among those with large premium volume. Profits among the large writers of disability insurance in New York have varied from small losses to profits in excess of 20 per cent of earned premiums.

There has been a greater uniformity among the large writers in loss and expense ratios with experience in New York than in the other states. On the other hand, there have been greater differences in dividends and experience refunds or credits granted. With New York experience these have varied from none at all to as high as 13 per cent of earned premiums. With some companies dividends or credits have been a large percentage of earned premiums even during years of losses. This was possible because of large dividends given to a few big risks, which in turn resulted from premiums for such risks being greater than required.

Small-Group Operations

Some companies have segregated disability data according to size of group insured.[56] Analyses of these data have shown results

[55] While this initial expense ratio may seem abnormally high in comparison with reported expense ratios in California and New Jersey, it must be remembered that initial expense ratios in these states, which were also high, were not reported. By the time reporting was required, expense ratios had leveled off to a sharply reduced rate.

[56] "Small" may refer to groups of less than fifty, or less than twenty-five, depending upon company practice.

contrary to the usual belief that small groups cannot be written profitably by insurance companies. While these data are not available for publication, for competitive reasons, it is known that the loss ratios for small groups have been surprisingly low. Several companies have experienced loss ratios as much as 15 to 25 per cent lower for small groups than for large groups. This has been attributed variously to wage-continuation programs which make employees ineligible for disability benefits, to presence of an esprit de corps which reduces malingering, and to the greater incentive to the member of a small group to return to work early. Streamlined administrative procedures have held expenses low, resulting in large profit margins.

Conclusion

Many insurance executives are extremely pessimistic concerning the future of private enterprise in the temporary disability insurance field. The pressure of persistently increasing benefits on the one hand, and relatively fixed premiums on the other, results in the "big squeeze" on the profit margin. The question of continuance of operations in California has been a subject of serious consideration by many companies. The 1953 and 1955 operating results in that state, however, may serve to mitigate this pessimism. With premium volume increasing, loss ratios leveling off, and expense ratios declining, the future seems less dismal.

In addition to the improved situation in California, most companies have had profitable operations every year in both New Jersey and New York. And while there have been several increases in statutory benefits in each state, the effect of these has been offset to some extent by lower expenses. It is expected that moderate profits will continue.

With more than a decade of valuable experience, with wide public support, and with profits reported by most companies in each state during recent years, it would appear that private insurance companies will be able to continue to play a vital role in compulsory temporary disability insurance.

CHAPTER • 10

Administrative and Legislative Problems

Some of the most controversial problems that have confronted the drafters of disability insurance have been administrative. What state agency should supervise the program and should this agency be limited to supervision or should it also administer an insurance system? And if the state does administer an insurance system, should this agency provide coverage exclusively or should private insurance plans be permitted? What are the comparative administrative costs of these different methods? These are the major problems to be discussed, along with other problems common to all programs, including the federal-state issue.

SUPERVISORY-ADMINISTRATIVE AGENCY

Under a system of state legislation, a state agency is necessary to co-ordinate, supervise, and sometimes administer the disability program. Some have recommended that a new agency be created for these purposes. But since economies can be achieved by integration with an existing agency, most discussions have centered around the relative advantages of integrating with the state unemployment compensation agency or the workmen's compensation agency.

This section will discuss which agency should supervise the disability program. The problem of whether or not this same agency should administer an insurance system will be discussed later.

Integration with Unemployment Compensation

The similarity in purpose of the temporary disability insurance and unemployment compensation programs is reflected in the similarity of their eligibility requirements, benefit formula, and

administration. Proponents of integration use the following arguments:[1]

Purpose. The purpose of both unemployment compensation and disability insurance is to protect workers normally employed against complete wage loss during relatively short periods when they are prevented from working—in one case by lack of work, in the other by inability to work. In contrast, workmen's compensation provides protection against hazards only of work-connected disabilities. Also, in addition to providing compensation for temporary total disability, workmen's compensation compensates for permanent total and permanent partial disability, and provides death benefits. These benefit provisions have no counterpart in temporary disability insurance.

Coverage. In most states all wage and salary workers, except those in agriculture, domestic service, government, nonprofit institutions, and, in some states, those in small firms, are covered by unemployment compensation. Most of the exclusions are for administrative reasons, and, it is claimed, are applicable equally to disability insurance. Co-ordinated disability-unemployment compensation coverage permits use of the same administrative machinery. Employers need only make one contribution and wage report. Duplicate records of covered employers, duplicate payments, duplicate delinquency reports, and duplicate auditing are avoided. Similar economies could not be achieved by co-ordinating with most workmen's compensation programs since many of them permit employers to elect not to come under the law or restrict coverage to certain hazardous employments.

Job Attachment. There is a similarity in job attachment of claimants for temporary disability insurance and claimants for unemployment compensation. Many unemployment compensation claims are paid for temporary layoffs, such as those due to bad weather, seasonal factors, retooling or material shortages. These individuals, while unemployed, usually return to the same employers, and they have a relationship with those employers which is similar to that of the disabled worker. The two groups

[1] U.S. Department of Labor, *Temporary Disability Insurance, Why Coordinate with Unemployment Insurance* (1951), pp. 1–10.

of claimants, it is maintained by proponents of integration, are sufficiently similar in this respect to justify integrated administration.

Eligibility. While it is agreed that the definition of eligibility for temporary disability insurances benefits differs from the definition of eligibility for unemployment compensation benefits, it is also maintained that it is different in greater degree than the definition used in workmen's compensation. The issue in disputed cases of temporary disability insurance (which pays only for total disability) is more likely to relate to the fact of disability itself, rather than to whether the disability is work connected; whereas, in occupational disability the question is usually not the source of disability but the extent of it. Moreover, diseases rather than accidents are the principal cause of nonoccupational disability.

Benefits. Unemployment compensation formulas have been subject to criticism because they sometimes permit payment to claimants no longer in the labor market, and because benefits are not based upon current wage losses. These deficiencies are admitted. It is contended, however, that in such cases the formulas are suitable neither for unemployed nor for disabled claimants. Revisions desirable for the one program would be desirable for the other.

Administration. In addition to the administrative advantages of co-ordination with unemployment compensation mentioned above, co-ordination also permits a joint staff to handle over-all administrative functions, research and statistics, and personnel and business-management functions more economically. It is admitted that many of these economies would also accrue to a program co-ordinated with workmen's compensation. It is claimed, however, that workmen's compensation agencies could not handle the large volume of weekly disability claims as expeditiously as could unemployment compensation agencies. The volume of nonoccupational temporary disability insurance claims is very much larger than that of occupational. Unemployment compensation agencies are geared to handle a large volume of claims on a weekly basis.[2]

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[2] Interstate Conference of Employment Security Agencies, *Sick Pay Benefit Legislation* (Helena, Mont.: Naegele Printing Co., 1947), p. 16.

Integration with Workmen's Compensation

Using very much the same analysis as their opponents, advocates of integration with workmen's compensation also present a formidable case.

Purpose. The purposes of workmen's compensation and temporary disability insurance are very similar. In the one case, provision is made for loss of wages due to occupational disability, in the other for loss of wages due to nonoccupational disability. Both programs are concerned with disabled claimants. Co-ordination of the two programs provides workers with twenty-four-hour disability coverage.

While it is true that workmen's compensation claimants must have been employed at the onset of disability, whereas most disability insurance programs provide benefits even to the unemployed, some believe that this latter group would best be covered by unemployment compensation rather than by disability insurance;[3] thus eliminating from a program co-ordinated with workmen's compensation the problems created by this group. Even granted that the disability insurance program should pay benefits to the unemployed, it is held that the administrative procedure should be designed best to accommodate the large majority of claimants rather than a small minority. In California, less than 9 per cent of disability insurance claimants are unemployed,[4] while in New Jersey less than half that proportion fall in this category.[5] These facts indicate that unemployment compensation is not a proper starting point from which to develop a disability insurance program.

Coverage. While coverage provisions of existing disability insurance laws are identical, or similar, to those for unemployment compensation, it is held that this is not necessarily desirable.[6] Many believe that both unemployment compensation and workmen's compensation laws should greatly extend their coverage

[3] See Chapter 8.

[4] California Department of Employment, *Report 1031A #4*, August 7, 1953.

[5] Estimated from reports in the *17th Annual New Jersey Employment Security Report.*

[6] Even in New York, the Disability Benefits Law coverage provisions more closely parallel unemployment compensation than workmen's compensation.

provisions.[7] However, failure to secure such extension in these programs should not restrict coverage provisions for disability insurance programs. The purposes of the disability insurance and workmen's compensation programs are sufficiently similar to warrant identical coverage provisions, providing both may be extended as desired.

Job Attachment. It may be true that in unemployment compensation there are many temporarily unemployed who return to their former employer; nevertheless, the majority do not return and the administrative procedure is designed for the latter group. Consequently, it is unsuitable to combine unemployment compensation with disability insurance, since only a relatively few claimants return to the same job after receipt of benefits.

Eligibility. Similarity of eligibility requirements provides one of the soundest justifications for co-ordinating disability insurance with workmen's compensation. With a considerable number of claims, the questions arises whether or not the disability is work connected. This question is best resolved with the help of the workmen's compensation agency. The volume of such borderline claims was considered sufficient to justify moving the New Jersey Workmen's Compensation Board from a separate building to the same building as that used by the disability insurance agency. One administrator of a disability insurance program co-ordinated with unemployment compensation stated confidentially that questions of eligibility alone justify his preference for co-ordination with workmen's compensation.

Benefits. The unemployment insurance benefit formula is not suited to disability insurance. This formula involves an extensive period of employment history for the determination of qualifications for and the amount of benefits. However valid for unemployment, it clearly has no place in determining the amount of disability benefit for employees who have a current attachment to an employer. Disability insurance is designed to replace wages lost on account of disability. Consequently, the amount of benefits should be based on, and should have a reasonable relationship

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[7] See Chapter 7.

to, earnings immediately preceding the commencement of disability. The use of unemployment compensation formulas frequently makes the amount of benefit too high or too low in relation to income at the commencement of disability.[8]

New Jersey found the usual unemployment compensation benefit formula unsuitable for disability insurance, and enacted changes. For example, it was formerly necessary for an individual to have earned twenty-five times his weekly benefit amount during the first four of the last five completed quarters immediately preceding the commencement of disability to be entitled to benefits. Now he has to have earned only $15 per week for seventeen of the fifty-two weeks preceding the disability. Thus entitlement is now dependent upon a more recent wage history. Benefit amount was formerly determined by the quarter with the highest total wages in any of the first four of the last five completed quarters preceding disability. This means that benefits may have been based upon wages earned more than a year prior to disability. Benefits are based at present upon wages earned during the eight-week period preceding disability.[9]

Administration. Administration of disability insurance by an agency that has had, in many states, thirty to forty years experience in administering disability benefits has been one of the main arguments of those favoring co-ordination with workmen's compensation. Since these agencies, in most states, have worked successfully with insurance companies providing statutory benefits, insurance companies have favored such co-ordination. Procedures have been developed and personnel trained by these agencies to administer disability claims. They have, as well, more or less secured the co-operation of the medical profession. Such important factors promote efficiency and economy of administration.

Many authorities in the field have gone on record as favoring the separation of disability insurance from unemployment compensation. William Beveridge is quoted as having said: "On the side of benefits (unemployment and sickness), unification of ma-

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[8] W. Ward Donohoe, "Integration of Private Disability Plan with State Law," *Conference Board Management Record*, June, 1949, p. 283.

[9] New Jersey Temporary Disability Benefits Law, R.S. 43:21–27, 40, 41.

chinery is excluded by the difference in the work to be done. At least two distinct types of machinery are indispensable, corresponding to the fundamental distinction between beneficiaries disabled by disease or injury and beneficiaries not so disabled. Nothing is gained by mixing oil and water; the sick and the whole."[10] Arthur J. Altmeyer, formerly commissioner for Social Security said: "Experience has shown that the two programs of temporary disability and unemployment are so different as to require almost separate administration, with separate policies, separate procedures and separate administrative staff."[11] Wilbur J. Cohen, technical adviser to the Commissioner for Social Security, has expressed substantially the same idea.[12] Perhaps the stronger support for co-ordination of disability insurance with workmen's compensation is provided by the almost unanimously agreed upon success of the administration of the New York Disability Benefits Law. No major administrative changes have been found necessary, nor has there been any serious criticism of the Law's administration.

Summary and Conclusions

The disability insurance program should be administered by an existing agency in order to take advantage of economies afforded. This agency, on balance, would seem to be the one that also administers workmen's compensation. This conclusion is based upon the desirability of co-ordination with an agency already experienced in dealing with disabled claimants, one which has the cooperation of the medical profession, and one which has had experience in supervising private plans. The problems that have arisen, and the changes found necessary in the programs co-ordinated with unemployment compensation, stress the advisability of co-ordination with workmen's compensation.

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[10] Mary Donlon, "New York's Disability Benefits Law," *Best's Fire and Casualty News*, June, 1949, p. 31.

[11] *Ibid.*

[12] Wilbur J. Cohen, "Recommendations to Improve the Old-Age and Survivors Insurance Provisions of the Social Security Act," *New York University, Second Annual Conference on Labor* (Albany: Matthew Bender & Co., Inc., 1949), p. 289.

SECURITY SYSTEMS

The agency chosen to supervise the disability program will influence to some extent the choice of security system. Three types of systems have received most consideration to date: the exclusive state fund, the all-private insurance system, and the state fund competing with self-insurance and private insurance. It is probable that integration with unemployment compensation would preclude the all-private insurance system, whereas integration with workmen's compensation would most likely preclude the exclusive state fund. Reasons for these influences and the pros and cons of the above alternatives will be reviewed here.[13]

Most social insurance programs make coverage compulsory. It has also been found necessary to make compulsory the provision of benefits through some insurance scheme. Failure to take this second step may result in a disabled employee being covered by the program but not being guaranteed the benefits stated in the law. The following three systems are different methods of providing the desired security of benefits.

Exclusive State Fund

This type of disability insurance system closely resembles present United States Unemployment Compensation laws. Contributions and benefits are administered by a monopolistic state fund. Private insurance carriers and self-insurance are given no opportunity to function here, other than to provide benefits supplementary to statutory. This type of law may be financed solely by employees, solely by employers, or by joint contributions. Contributions may be assessed uniformly on all employers or varied by experience rating.

Proponents of an exclusive state fund system argue that it is simplest and cheapest to administer. These administrative economies make possible, it is claimed, a higher proportion of benefits to contributions than any other type system. It is claimed also that

[13] Interstate Conference of Employment Security Agencies, *op. cit.*, pp. 27–36; New York Department of Labor, *Studies in Disability Insurance* (1949), pp. 77–103.

more adequate benefits are usually provided.[14] This claim is based upon the premise that all other systems create a "vested interest" on the part of employers and insurance companies and that they tend to hold down benefits. An exclusive state fund permits the broadest pooling of the disability risk because it enables those who need the coverage most, and who are also the poorest risks, to obtain benefits at the lowest cost.

Administrative economies, previously mentioned, are achieved in several ways. Probably of greatest importance is the fact that acquisition costs would be negligible. Coverage with the state fund would be compulsory, eliminating the need for sales expenditures. Premium taxes, which may be as high as 4 per cent of contributions,[15] would be eliminated. The state fund would have the further advantage of effecting savings through co-ordination of certain activities with existing governmental agencies, such as workmen's compensation or unemployment compensation.

The elimination of costs necessary to provide for supervision of private plans would be an advantage over an all-private or a competitive-state-fund system. One advantage over the latter is that there would be lower unit costs if the state fund covered all workers rather than just a portion of them. Another is that adverse selection may leave the state fund with a large proportion of small groups which are more costly to administer.

Labor usually prefers an exclusive state fund, because it believes such a system gives the worker most for his money. Also, it is contended, since insurance is compulsory, it is impossible to justify a profit to an insurer which would result in the payment of benefits lower than might otherwise be possible.

The most articulate opponents of the exclusive state fund are employer groups and insurance companies. The opposition of the latter group is to be expected, since an exclusive state fund practically excludes commercial group accident and sickness insurance. The primary basis for employer opposition seems to be that

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[14] These claims are not validated by experience in this country. See Chapter 8 and section on "Administrative Costs" below.

[15] For the opposition's rebuttal to this, see below.

such a system restricts free enterprise and gives rise to more "government in business." Other arguments put forward are: governmental administration is relatively inefficient; inadequate claim administration leads to widespread malingering; such a system is inflexible and unable to adapt to individual needs. Another argument of the opposition, for which evidence is lacking, is that workers previously covered by voluntary programs often suffer a reduction in benefits upon passage of an exclusive state fund law.

This is the system employed in Rhode Island and in the railroad plan. The relatively large number of problems that have arisen in Rhode Island have brought this system into ill repute. This is unfortunate since many of the problems have been due to the specific law rather than to the system itself. On the other hand, few problems have arisen in the railroad program. Its unique status, however, limits the usefulness of its experience for state programs.[16]

All-Private Insurance System

Under this system benefits may be provided by self-insurance or by commercial carriers. There is no state fund. Financing is most likely to be joint, or exclusively by employers. Exclusive financing by employees is not probable, since passage of this type of system would indicate legislative influence by employers who prefer to share in the financing. Uniform contributions for all employers are possible but, in the nature of the reasons for the system, not logical.

Much of the argument for an all-private system (equally pertinent for private plans with a competitive state fund) is based upon this thought—"What you buy with your money is just as important, if not more so, than the number of dollars you spend."[17] It may be true, but not necessarily, that state funds can operate with lower expenses. But such savings are frequently at the expense of good administration. The heart of a disability insurance program is claim administration. Private plans pay claims

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[16] See Preface.

[17] Harold R. Elliot, "The New York Disability Benefits System," *Industrial and Labor Relations Review*, April, 1951, p. 438.

faster,[18] thus promoting greater co-operation of employees and employers. Moreover, better administration of claims results in lower benefit expenditures. Consequently, even if expenses are greater, over-all costs of the program may be less.

Private enterprise, it is claimed, is nearly always more efficient than government. Skilled, energetic men prefer private enterprise with its greater rewards and opportunities for development. These greater rewards are not at the expense of economy, since they produce lower unit costs. Another advantage claimed by insurance companies is that they have large staffs of skilled personnel who are already experienced in administering disability insurance.

Insurance companies insist that the over-all cost to the economy of the different systems should be considered. The premium, corporate income, property, and other taxes paid by the companies are expenses which state funds do not have.[19] However, these costs cannot be considered a net loss to the economy. These taxes serve to finance necessary governmental services. If these expenditures were not made by the companies, employees and employers would have to pay additional taxes.

Another factor to be considered in any cost comparison is that state funds benefit from certain subsidies. Other than having no taxes to pay, they sometimes benefit from low rental charges and receive free, or pay only token charges for, services from other governmental agencies.

Other arguments for and against an all-private insurance system are substantially the opposite of those for an exclusive state fund. No state disability program is of this type, although precedents are to be found in workmen's compensation.

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[18] An unpublished study by the New Jersey Disability Insurance Service revealed that payment of a claim by the State Fund takes an average of 14.8 days. No information is available on a comparable study by an insurance company. Several company officials stated, however, that 90 per cent of their claims are paid within one or two days.

[19] Insurance companies paid $2.2 million, 4.5 per cent of earned premiums, in taxes for 1953 from disability insurance premiums in California. The industry has long contended that the premium tax is unjust. In this instance, the equity of financing general state services through a payroll tax, levied only on covered payrolls, is questioned.

State Fund with Commercial Insurance and Self-Insurance

This type combines features of both the exclusive state fund and the all-private insurance type. This system provides that coverage may be obtained from the state fund, from a commercial carrier, or through self-insurance. The private insurance plans, including self-insurance, are subject to supervision by the state disability agency. Financing may be exclusively by employers, or by employees, or both. Contributions may be uniform or varied by experience rating. If uniform contributions are assessed, however, a provision may be necessary whereby the state fund is protected against adverse selection.

There are two modifications of this type of system, depending upon the status of the state fund. With the first, coverage is automatic with the state fund, but those desiring may "contract out," i.e., they may obtain coverage with a private carrier or through self-insurance. With the second, there is no automatic coverage with the state fund; those desiring coverage must select the state fund, a commercial carrier, or self-insurance. The state fund operates in much the same manner as the private carriers, differing primarily in that the fund must accept any risk that applies for coverage.

While some cost advantages of a monopolistic fund are admitted, they may be relatively minor. A competitive fund in most states would be able to cover a sufficiently large number of employees to effect great economies, regardless of the proportion of total covered employees insured. Mechanized procedures permit relatively economical administration of even small groups. The costs attributable to the supervision of private plans are charged to them, not the fund. It is maintained that factors such as geography of the state, average size of employee groups, and administrative efficiency, which are independent of whether the fund is monopolistic or competitive, are more important than some of the factors listed above.

Some opponents of the dual system claim that insurance companies will tend to select the better risks, leaving the state fund with the high-cost groups. Opponents from the other wing object

to the provision for automatic coverage with the state fund found in the first subtype. This discriminates against the private carriers, they claim, and adds to their acquisition costs.

The competitive state fund seems to be the most acceptable compromise between the all-private insurance system and the exclusive state fund. And like most compromises, it fails to satisfy the more ardent proponents of either extreme position. Those who favor this type point out that it provides a means whereby all can obtain the required coverage, while at the same time it permits those desiring more liberal provisions a means of obtaining them. Some believe that the competition between the state plan and private plans, afforded by this system, provides benchmarks for both competitors and improves the over-all program. A practical advantage of this system is that it is acceptable to most labor groups as well as to employers and insurance companies. Notwithstanding the preference of both groups for more extreme programs, the compromise has received wide support.

The first variation of this system is employed in California and New Jersey. While there are differences between these two plans, e.g., they differ as to source and method of assessing contributions, they are basically alike. The second variation is found in New York.

PRIVATE PLANS

In California, New Jersey, and New York private insurers provide a large proportion of the required coverage. Most of this coverage is provided by commercial insurance companies. There are, however, many self-insured groups.

Commercial Carriers

There is a considerable disparity in the statutes and regulations of the states under which the carriers have had to operate. The experience of these commercially insured groups, therefore, will be studied by state.

California. Most insurance companies have had more prob-

lems while writing compulsory disability insurance in California than in either New Jersey or New York. The consensus is that these problems arise from the statutes themselves rather than from the administration of the statutes. Indeed, the administrators of the program in California have often been commended by the industry for their co-operative attitude.

The "greater than" provision has handicapped the companies in competing with the State Fund. This provision states that approval will be granted only to those private plans that afford the covered employees rights greater than those provided by the state plan.[20] This has been interpreted to mean that the private plan must in general afford covered employees benefits equal to those provided by the state plan and, in at least one significant respect, greater benefits. These benefits must be provided despite the fact that workers cannot be required to contribute more than 1 per cent of payroll.

The requirement has been met in a variety of ways. Many plans have provided a higher weekly benefit amount; others a shorter waiting period or elimination of the waiting period for accidents; still others a uniform twenty-six-week duration instead of variable duration with a maximum of twenty-six weeks. The companies always have objected to this provision in principle, although they had little difficulty complying with it during the early years of operation. But statutory provisions have been steadily raised, utilization of benefits has increased, while at the same time contributions have remained the same. Hence this provision has become a burden. It is believed that the state supervisory agency has become more lenient in its interpretation of this section, consequently the margin between the benefits granted by private plans and by the State Fund has steadily narrowed. Recently private plans have been approved in which the excess of benefit has been negligible.

It is difficult to justify this "greater than" provision. While there should be minimum benefit standards for private plans, and opportunities for increased benefits where desired, the minimum

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[20] California Unemployment Insurance Code, Section 3254.

standards should not be greater for one system than for the other. When the competing systems are held to the same contribution standard, equity would seem to demand that they be held to the same benefit standard. Elimination of the "greater than" provision would probably strengthen the program.

Increased acquisition costs for commercial carriers have been attributed to the provision that all eligible groups are automatically covered by the State Fund, unless the employer decides otherwise. The insurance industry believes that this puts an added burden upon the carriers: it is more difficult to convince a group to switch from the State Fund to a private carrier than it would be to sell the group on a private plan in the first place. The provision is defended on the ground that it provides employees greater security. This desired security can be achieved by better methods.[21] If private insurers are to be permitted, it seems unjust to handicap them with an automatic-coverage provision.

Another factor adding to acquisition costs in California is the requirement that 85 per cent of eligible workers must consent to the private plan before it can be made applicable to the group. The consent of the employees must be obtained in writing, and these documents must be kept available for agency inspection. Even though a majority of the workers accept the plan, individuals may elect coverage with the State Fund.[22]

This rather elaborate procedure has added to the costs of the carriers. It has been defended on the ground that it affords the individual employee maximum opportunity to express his choice of program. Adequate opportunity for such expression would seem to be permitted if the consent of a bare majority were made the requirement, with no individual permitted to elect out. This would result in savings for the State Fund as well as for employers and carriers.

The scale of benefits provided by the California statutes has been a problem to the companies. The weekly benefits have always been relatively high; the current maximum of $40 a week is

[21] See section on "New York" below.

[22] It has been estimated that 10–15 per cent of the workers eligible for coverage under a private plan have elected the State Fund.

as high as any of the four states with disability insurance laws. In addition to the high weekly benefits, the law also provides for a cash hospitalization benefit of $10 per day for twelve days. And when the claimant is hospitalized, the remaining part of the waiting period, if any, is eliminated.[23] While the effect of this benefit scale has been offset partially by high taxable wages, the companies have had difficulty keeping in the black.

The State Fund has provided keen competition for the carriers. The Fund has no solicitors, nor "educational representatives"; nevertheless, the high quality of service provided has served as a yardstick by which the carriers are measured. Intercarrier competition has also been a problem in California. Many company men have expressed the opinion that group disability competition, of which compulsory insurance has been a part, has been more acute in California than in any other state—at times even cutthroat.[24] Competition has been most keen for large groups, where competitive bidding has led, at times, to such high benefit schedules that underwriting losses were almost assured. Companies frequently have entered the field by "buying business."[25] Such practices have made profitable operations difficult. Most of the companies that engaged in these practices desisted after several years of high loss and expense ratios.

Until 1953 there was also a statutory provision that prohibited approval of private plans if they resulted in a substantial selection of risks adverse to the State Fund. This created more problems for the carriers. Since adverse selection is a problem common to the other state programs, it is discussed later in this chapter.

During the years under consideration there has been a notable trend in coverage away from the State Fund to private plans. The peak of employee insurance under private plans was reached in

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[23] California Unemployment Insurance Code, Sections 2801–2.

[24] Early in 1952, the insurance commissioner in California called a meeting with companies writing group disability insurance to deal with this problem. The companies were told they must abstain from questionable competitive practices or be subject to closer regulation.

[25] John S. Bickley, *The Impact of a State Disability Act on Insurance Companies: A Study of the California Experience*, Research Monograph Number 77 (Columbus: The Ohio State University, Bureau of Business Research, 1954), p. 26.

1953. Since that time there has been some shifting in coverage back to the State Fund. The estimated average number of employees insured under private plans in 1948 was 750,000 or 31.5 per cent of all insured persons. The number increased to 1,604,000 in 1953, which was 53.5 per cent of the total. In 1955, the average number of employees insured under private plans was 1,464,000, which corresponded to 45 per cent of all insured persons. The expansion in private-plan coverage reflected a movement of employment units from the State Fund to private plans as well as the growth of the total covered labor force. There was relatively little shifting of coverage between private plans and the State Fund in 1955, thus indicating a measure of stabilization in this respect.

TABLE 12

ESTIMATED AVERAGE NUMBER OF COVERED EMPLOYERS AND EMPLOYEES, TOTAL AND PRIVATE PLANS, CALIFORNIA DISABILITY INSURANCE PROGRAM, 1947–55

	Employers			*Employees*		
Date	*Total*	*Private Plan*	*Private Plan as Percentage Total*	*Total*	*Private Plan*	*Private Plan as Percentage Total*
1947	221,500	7,750	3.5	2,475,000	510,000	20.7
1948	234,500	12,300	5.2	2,358,900	750,700	31.5
1949	236,900	24,900	10.3	2,498,600	965,600	38.8
1950	236,900	31,300	13.1	2,562,500	1,210,100	47.2
1951	241,400	32,600	13.6	2,709,900	1,439,900	53.0
1952	245,300	32,400	13.2	2,861,400	1,539,200	53.3
1953	249,100	34,314	13.8	3,004,800	1,604,100	53.5
1954	257,753	31,113	12.0	3,057,200	1,397,000	45.7
1955	265,016	31,329	12.6	3,257,200	1,464,100	45.0

Source: California Department of Employment, *Report of the Actuaries for Calendar Year 1955*, June 27, 1956 .

Insurance companies have concentrated their coverage on large employers. This is demonstrated by the fact that in 1955, while employers with private plans constituted little more than 12 per cent of all covered employers, they employed 45 per cent of all covered employees.

New Jersey. Operating experience acquired in California aided the insurance companies in New Jersey. Also, some of the New Jersey statutes were easier for the companies to comply with. For example, benefits provided by private plans need be only equivalent to those of the state program, not "greater than." If a majority of the workers approve the plan, all the workers in the establishment are automatically covered. It is not possible for an individual in a group covered by a private plan to elect coverage with the State Fund. Workers in liable firms, as in California, are automatically insured by the State Fund unless the employer has

TABLE 13

ESTIMATED AVERAGE NUMBER OF EMPLOYERS AND EMPLOYEES, TOTAL AND PRIVATE PLANS, NEW JERSEY DISABILITY INSURANCE PROGRAM, 1949–55

	Employers			*Employees*		
Date	*Total*	*Private Plan*	*Private Plan as Percentage Total*	*Total*	*Private Plan*	*Private Plan as Percentage Total*
1949	42,200	14,600	34.5	1,279,000	766,000	60.0
1950	43,500	15,600	35.9	1,294,000	846,000	65.3
1951	45,700	16,000	35.0	1,394,000	924,000	65.2
1952	47,600	17,400	36.5	1,425,000	991,000	69.6
1953	48,800	16,800	34.5	1,466,000	953,000	65.0
1954	50,400	16,600	33.0	1,427,000	927,400	65.0
1955	51,900	16,200	31.0	1,462,000	927,900	64.0

Source: New Jersey Division of Employment Security Annual Reports; and U.S. Department of Labor, *New Jersey Disability Insurance Program* (1950).

an approved private plan. Prior to the effective date of the New Jersey law, however, insurance companies were prepared to contact any group they desired. This eliminated the sales effort necessary to convince a group to "switch." Statutory weekly benefits have not been as high in New Jersey as in California, nor have there been hospital benefits. Recent benefit increases, accompanied by a decrease in rate of employee's contributions, however, have made profitable operations more difficult.

There has been a substantial increase in the number of employ-

ers covered under the Disability Insurance Program in New Jersey since 1949. Most of the increased number of employers, however, have been insured with the State Fund. An increasing number of employees were insured with private plans from 1949 to 1952. Because of the higher premiums required when employee contributions were reduced in 1953, there was a shift of groups from private plans to the State Fund. There was relatively little of this shifting in 1954 and 1955. The workers covered under private plans are predominantly in larger establishments. Table 13 indicates that whereas less than 35 per cent of covered employers are insured with private plans, these same employers employ approximately 65 per cent of all covered employees.

New York. The New York Law was tailored for insurance companies—and some say, by the companies.[26] Consequently, company experience has been relatively satisfactory. One reason for this, it is believed, is that the companies have made an extraordinary effort to co-operate in making the New York system successful, in order to set an example for other states considering such legislation. Company officials, without exception, cite New York as having the best temporary disability insurance laws.

The New York Law is heralded for its flexibility. One example is the Board ruling[27] that some features of a private plan can be less favorable than the standards of the state law if other features of the plan are more favorable. Medical, hospital, and surgical care benefits, for example, may be substituted up to the equivalent of 40 per cent of the statutory cash benefits.[28] Information is not available as to just how many plans take advantage of this ruling, but they are not numerous.

The New York Law, which does not provide for automatic coverage, meets the problems of noncompliance by paying bene-

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[26] See Chapter 4.

[27] Rule 10, pursuant to the provisions of Article 9 of the New York Workmen's Compensation Law.

[28] It has been suggested that employers make a mistake if they take advantage of this ruling. A sick employee, not eligible for hospital or medical care benefits, may thus receive 40 per cent less than the statutory cash minimum. This situation, which could hinder employee relations, should be corrected by slightly higher premiums.

fits from a Special Fund to those disabled employees for whom no coverage has been obtained The recalcitrant employer is subsequently fined and forced to comply with the law. The New York system, it is claimed, is more favorable to commercial carriers than are those in California or New Jersey, and yet provides adequate safeguards for employees.

The insurance companies made a prodigious effort to provide coverage for all eligible groups at the outset of the program. As a result they were able to obtain approximately 83 per cent of the available business. Of the remainder, the State Insurance Fund obtained approximately 3 per cent, 8 per cent was with self-insured employers, and 6 per cent was with self-insured associations.

In 1955, approximately 60 per cent of eligible employees in the state were covered by plans providing benefits in excess of statutory minima.[29] Of this group 48.2 per cent had the entire cost of the plans paid by their employers. Of the 1,885,363 employees for whom statutory benefits were provided, 82.1 per cent made some contribution to cost of their benefits. It is interesting, however, that approximately 83 per cent of the employees of self-insured employers made no contribution to the cost of their benefits.[30]

Self-Insurance

The three states permitting private plans permit self-insurance. Provisions prohibiting payment of disability benefits to employees receiving a continuation of salary during disability, formerly found in California and New Jersey, encouraged self-insurance. An employer with an established salary-continuation program would hesitate to pay premiums to the state for benefits that his employees would seldom receive. Many large groups have preferred to self-insure for reasons of economy. Those firms anticipating a loss experience better than the average may well decide to self-insure, as may those for whom savings in acquisition costs and premium taxes are significant.

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[29] New York Workmen's Compensation Board, *1955 Annual Report*, p. 17.
[30] *Ibid.*

TABLE 14

ESTIMATED AVERAGE NUMBER OF EMPLOYERS AND EMPLOYEES CLASSIFIED BY CARRIER, NEW YORK DISABILITY BENEFITS LAW, 1951–55

(Add 00)

	Employers					*Employees*				
Date	*Total**	*Commercial Carrier*	*State Insurance Fund*	*Self-Insurance*	*Association†*	*Total*	*Commercial Carrier*	*State Insurance Fund*	*Self-Insurance*	*Association*
1951	1,633	1,367	151	4.8	150	45,985	38,100	1,562	3,605	2,718
1952	1,800	1,535	149	5.4	152	46,216	37,950	1,534	3,879	2,853
1953	1,825	1,548	153	4.5	154	47,238	38,637	1,750	3,927	2,924
1954	1,834	1,566	151	4.4	147	46,155	37,590	1,732	3,961	2,872
1955	1,932	1,672	152	4.6	145	46,317	38,317	1,745	4,122	2,349

* Totals for employers do not add up because some employers have employees with both the State Insurance Fund and Associations.

† "Associations" are primarily self-insured union groups. In 1955 there were 55 associations with 14,502 participating employers.

Source: Annual reports of the New York Workmen's Compensation Board, and information from the New York State Insurance Fund.

Insurance companies contend, however, that many of these savings may not be realized or may be outweighed by other factors. Among the considerations to be weighed carefully before making a decision to self-insure, is the necessity of employing and training competent personnel to administer the program. Inadequacies in this respect may be very costly. In addition, the experience of some groups is that better employee relationships are maintained by having disability benefits administered by a third party. Misunderstandings easily arise in a benefit system. A third party can often more easily resolve such misunderstandings; and in the event an amicable settlement is not reached, it is better that the employee's resentment be directed toward the third party.

Other factors to be considered prior to self-insuring are:

1. Under a self-insured plan an employer must deposit securities or file bond as evidence of financial responsibility and must furnish to the state an annual statement of his assets and liabilities.

2. A self-insured plan must be formalized and then approved by the appropriate agency. If approved, the plan will be under the agency's jurisdiction. Consequently the process often entails much more supervision and detail than originally anticipated.

3. Epidemics and catastrophes could produce burdensome losses. Should these situations occur without adequate excess-loss insurance, the employer would be subject to unanticipated costs.[31]

There are relatively few self-insurers of disability insurance in California, approximately 60, although some of these employ as many as 20,000 employees.[32] In New Jersey there were 157 self-insurers in 1952, employing 108,774 employees. It is interesting that employees in the self-insured plans represent less than 13 per cent of all employees under private plans, yet they received almost 25 per cent of all benefits paid to such groups. Assuming the disability rates for the groups are similar, these data suggest

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[31] Prudential Insurance Company of America, *The Way to N.Y. DBL Sales*, a company sales Bulletin (1950), p. 16. These principles apply also to self-insured plans in California and New Jersey.

[32] Information from the Division of Disability and Hospital Benefits, California Department of Employment.

that the self-insured plans have more generous benefit schedules.[33] At the end of 1955 there were 526 self-insured groups in New York with 647,139 employees.[34]

Among the needle trades, particularly in New Jersey and New York, unions have established self-insured groups on a craft-wide basis. Many of these unions have long-established programs for providing their members with various welfare benefits. Since many of the programs already provided cash disability benefits, they were simply amended to comply with the statutes. Some of the programs paid weekly disability benefits as low as $12 or $15. Since many were established prior to the passage of the New York law, they could have qualified by statute without increasing the weekly benefit; but, rather than set a poor precedent for employers, the benefits were increased to the statutory minimum. These self-insured union associations represent approximately 6 to 7 per cent of employees under both the New York and New Jersey programs.[35]

Summary and Conclusions

There has been a marked increase, since 1947, in the number of employees covered by private plans in California, in spite of several inhibiting statutes. Approximately 45 per cent of eligible employees in California are now covered by private plans. Insurance companies contacted employers in New Jersey prior to the effective date of the law, and were successful in writing a large proportion of the eligible groups there. Private plans function more easily under the statutes in New Jersey than in California. Without question the New York statutes are most favorable for private plans. As a consequence, the State Insurance Fund covers only about 3 per cent of eligible employees. Significant, too, is the fact that approximately 60 per cent of employees in New York are covered by plans with benefits in excess of statutory minima.

Judging from the growth of private plans in California and in

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[33] New Jersey Division of Employment Security, *Summary of Reports with Respect to Benefits Paid Under Approved Private Plans During 1952*, August, 1953.

[34] New York Workmen's Compensation Board, *1955 Annual Report*, p. 18.

[35] *Ibid.;* also New Jersey Division of Employment Security, *op. cit.*

New Jersey regardless of restricting statutes, it would appear that employees as well as employers prefer private plans. In recognition of this preference it seems prudent to enact legislation that will permit private plans. The marked success of the New York program suggests its use as a pattern.

ADMINISTRATIVE COSTS

An important consideration in a temporary disability insurance program is cost of administration. This has led to considerable discussion of the relative merits, in this respect, of alternative systems. Sufficient time has elapsed to permit an appraisal of the different programs. This section will discuss administrative costs of each state fund, as well as average administrative costs of insurance companies writing temporary disability insurance.

Rhode Island

Inadequate allowance for administrative expenses has been characteristic of the monopolistic Rhode Island system. This allowance was first limited to 1 per cent of contributions, which was grossly inadequate. It had been assumed that most of the administrative burden of the disability program would be borne by unemployment compensation. When this assumption proved to be wrong the appropriation was increased to 3 per cent. This, too, proved inadequate. In 1946 there was an increase to 4 per cent, and since at the same time the contribution rate was increased 50 per cent (from 1 per cent to 1.5 per cent of payroll), the funds available for administration were doubled. When the contribution rate was reduced to 1 per cent the following year, the allowance for administration was raised to 6 per cent. It has remained at this level.

For each of the past five years administrative expenditures have been close to the permitted maximum. Yet the Department's annual report has mentioned nearly every year that administrative funds have been inadequate to do the job required. The 1953 report said: "Although these methods provide the best means for

controlling fraud or malingering, it was necessary to drastically reduce both field investigations and impartial medical examinations because of the lack of funds. Unless funds for this purpose are increased, further curtailment may be necessary."

TABLE 15

ADMINISTRATIVE COSTS OF THE RHODE ISLAND TEMPORARY DISABILITY INSURANCE FUND, 1943–55

Date	*Net Contributions*	*Administrative Costs*	*Per Cent of Contributions*
1943	$4,672,442	$ 66,038	1.41
1944	4,572,383	130,110	2.84
1945	4,388,557	141,482	3.22
1946	4,896,537	153,543	3.13
1947	6,985,270	172,223	2.46
1948	5,521,595	211,736	3.83
1949	5,035,345	268,765	5.33
1950	5,373,510	293,948	5.47
1951	6,079,557	357,872	5.88
1952	5,940,408	334,155	5.62
1953	6,287,008	371,002	5.91
1954	5,730,603	373,917	6.53
1955	5,896,588	337,482	5.70

Source: Rhode Island Department of Employment Security, Temporary Disability Insurance, *Summary of Financial and Related Data* (Mimeographed), June 17, 1953; and Department of Employment Security, Rhode Island, *Annual Reports.*

California

Originally the allowance for administrative costs was 5 per cent of contributions. In addition to this, the administration account is credited with the special assessment levied against private plans for the added administrative costs attributable to them. This assessment is prorated among private plans on the basis of wages paid to the individuals participating in such plans. This assessment is limited to 0.02 per cent of such wages. This has always been an adequate maximum.

During the first two years of operation, when the state plan covered a majority of eligible workers, the administrative allowance was more than adequate. But as more workers changed to private plans, contributions to the state plans were reduced. Since the administrative load was not decreased proportionately (be-

TABLE 16

ADMINISTRATIVE COSTS OF THE CALIFORNIA TEMPORARY DISABILITY INSURANCE FUND, 1947–55

Year	*Net Contributions*	*Administrative Costs Including Private-Plan Assessments*	*Percentage of Contributions*	*Administrative Costs Excluding Private-Plan Assessments*	*Percentage of Contributions*
1947	$51,512,181	$1,787,793	3.5	$1,787,793	3.5
1948	46,254,703	2,146,967	4.6	2,083,138	4.5
1949	36,586,503	2,507,938	6.9	2,269,311	6.2
1950	33,104,328	2,177,509	6.6	1,850,913	5.6
1951	34,120,673	2,637,210	7.7	1,557,238	4.6
1952	36,359,136	3,029,446	8.3	2,204,908	6.1
1953	40,109,768	3,213,966	8.0	2,407,119	6.0
1954	43,774,503	3,618,220	8.3	2,998,287	6.8
1955	47,915,139	3,401,556	7.1	2,318,042	4.9

Source: California Department of Employment, *Report 1009 #13*, February 14, 1956.

cause of fixed costs), the 5 per cent allowance became inadequate. In recognition of this, the 1951 legislature removed the percentage limitation on administrative expenditures, which are now determined by the agency subject to approval by the State Director of Finance.

It is evident from Table 16, that administrative costs have increased substantially, both absolutely and as a percentage of contributions, since the beginning. Since 1950, total amounts expended have doubled. In 1954, the year of greatest administrative expenditures, the ratio of administrative costs to contributions, excluding private-plan assessments, was almost double the original expenditure of 3.5 per cent; if assessments against private plans are included, the ratio is still greater. Experience in 1955 indicates that administrative expenditures, as a percentage of contributions, may have reached the maximum. These figures indicated that good administration is not achieved at low cost.

New Jersey

Determination of administrative allowances for New Jersey has followed the California pattern. The statute originally permitted 6 per cent of contributions, in addition to private plan assessments for administrative purposes. The assessment against private plans is limited to 0.02 per cent of taxable payrolls.

The administrative allowances even for the first two years of operations were inadequate. Had it not been for a surplus in the administrative account, accumulated prior to payment of benefits in 1949, there would have been a deficit. When the employee contribution rate was reduced from 0.75 per cent to 0.5 per cent in 1952, changes were also made in the administrative allowance. It was recognized that contributions, the base upon which administrative allowances had been made, would be curtailed without a parallel reduction in administrative costs. The administrative budget since then has been determined by the legislature upon the recommendation of the Disability Insurance Service, subject to a maximum of 0.08 per cent of wages. To this are added private plan administrative assessments. Thus, the maximum percentage was raised at the same time that a more stable base was selected.

TABLE 17

ADMINISTRATIVE COSTS OF THE NEW JERSEY TEMPORARY DISABILITY INSURANCE FUND, 1949–55

Year	*Net Contributions*	*Administrative Costs Including Private-Plan Assessments*	*Percentage of Contributions*	*Administrative Costs Excluding Private-Plan Assessments*	*Percentage of Contributions*
1949	$10,422,104	$ 969,522	9.9	$787,411	7.6
1950	9,587,959	1,056,642	11.0	634,479	6.6
1951	9,296,273	990,024	9.9	526,886	5.7
1952	9,701,158	1,053,386	10.9	654,503	6.8
1953	8,611,002	1,184,410	13.8	706,553	8.2
1954	9,076,337	1,204,065	13.3	732,951	8.1
1955	9,610,442	1,228,658	12.8	763,426	7.9

Source: Annual Reports of New Jersey Department of Employment Security and letter from the Superintendent of Disability Insurance Service.

Administrative expenses gradually have increased in absolute amounts since 1950. While these expenses, as a percentage of contributions, increased up to 1953, there has been some decrease in this percentage since then. The percentage increase in that year is attributable largely to the marked reduction in contributions with a slight rise in total expenditures. Administrative expenses, both in absolute totals and as a percentage of contributions, have increased approximately 30 per cent since the commencement of the program.

New York

Workmen's Compensation Board. With private plans providing most of the benefits, administrative expenditures by the Board for the Disability Benefits Law are primarily for supervision of private plans. Some benefits are paid to the unemployed from the Special Fund, which is administered by the Board.[36] Costs attributable to the supervision of private plans by the Board are assessed against insurance companies, self-insurers, and the State Insurance Fund. These costs, determined at the end of the fiscal year in March, are assessed in the proportion that payrolls covered by the carrier bear to the entire payroll of covered employment in the state.

The first Disability Benefits Law assessment of $1,953,103 levied in 1951 included $411,910 for 1950. This represented approximately 0.0225 per cent of taxable payrolls. The 1955 assessment of $1,452,075, which was approximately 0.0118 per cent of payrolls, was a slight increase, both in total and as a percentage of payrolls, over 1954.[37]

New York State Insurance Fund. The Fund, it will be recalled, pays premium taxes and assessments as do commercial insurance companies. It differs from commercial companies in that acquisition costs are very low,[38] and it must take all who

[36] See Chapters 6 and 8.

[37] New York Workmen's Compensation Board, *Annual Reports.*

[38] Acquisition costs for the Fund in 1955 were 1.1 per cent of earned premiums. The same figure for an average of all commercial carriers writing disability insurance that year in New York was 6.8 per cent. Data from the New York State Insurance Fund and the New York Insurance Department.

apply for coverage. As a consequence of the latter, the Fund has a proportionately large number of small groups. These factors contributed to an expense ratio (total expenses to earned premiums) of 15.1 per cent for 1954, and 14.4 per cent for 1955.[39] The statutes limit administrative costs to 25 per cent of earned premiums.

Insurance Companies

Many believe that insurance companies competing for temporary disability insurance are most vulnerable to criticism for their high expense ratios. Commissions and other acquisition costs have been particularly subject to censure. The companies have acknowledged their higher costs, but have justified them by asserting that their insureds receive better service.

The experience in the two states for which a series of data are available indicates that the companies have been constantly reducing expenses as a proportion of earned premiums. The trend is particularly evident for acquisition costs. The average expense ratios for companies operating in California have decreased from 23 per cent in 1949, the first year for which data are available, to 16.2 per cent in 1955. The acquisition expense ratios for the same years were 12 and 7.1 per cent, respectively.[40] In New York the average expense ratio was 29.7 per cent,[41] for the last half of 1950, while it was only 16.9 per cent in 1955. Acquisition expense ratios for those years were 12.6 and 7.1 per cent respectively. The average total expense ratios for New Jersey in 1952 and 1955 were 15.4 and 14 per cent, respectively, while the acquisition expense ratios for the same years were 5.9 and 4.9 per cent, respectively.

Summary and Conclusions

Evidence is not conclusive that the monopolistic state fund is the most economical method of administering disability insur-

[39] Data from the New York State Insurance Fund.

[40] From reports filed with the California Insurance Department.

[41] The high expense ratio for 1950 reflects the high costs incurred in initiating the program.

TABLE 18

ALL-INSURANCE COMPANY AVERAGE ADMINISTRATIVE EXPENSES AS A PERCENTAGE OF EARNED PREMIUMS FOR DISABILITY INSURANCE WRITTEN IN CALIFORNIA, NEW JERSEY, AND NEW YORK, 1949–55

	1949	*1950*	*1951*	*1952*	*1953*	*1954*	*1955*
California:							
Total expenses	23.0	20.7	18.5	18.1	17.2	17.3	16.2
Acquisition expenses	11.6	10.5	8.9	8.2	7.7	7.5	7.1
New Jersey:							
Total expenses	*	*	*	15.4	15.0	14.9	14.0
Acquisition expenses	*	*	*	5.9	5.6	5.1	4.9
New York:							
Total expenses	*	29.7†	19.8	17.6	17.5	17.1	16.9
Acquisition expenses	*	12.6†	9.1	7.6	7.1	7.3	6.8

* Not available.
† Last Six months.
Source: Reports from the respective state insurance departments.

ance, all things considered. Rhode Island's dollar costs have been the lowest, but by official admission it has been at the expense of good administration. The costs of the California and New Jersey programs, exclusive of those assessed private plans, are probably about what Rhode Island's costs would be if Rhode Island were able to finance its administration as needed. The cost differences among the states are probably due more to factors such as quality of personnel, state geography, and type of industry, than to type of security system.

With private-plan costs steadily decreasing and most state-fund costs steadily increasing, the administrative-cost margin between an all-private and a competitive state fund is narrowing. If it were possible to calculate the administrative-cost subsidies benefiting the state funds, and the claimed reduction in benefit costs attributable to the more effective claim administration of commercial carriers, the difference in cost of administering the two systems would be even smaller than at present.

Since administrative-cost differences seem to be growing smaller, the choice of plan must rest essentially upon a philosophic

basis, rather than an economic basis. Proponents of private plans might well echo the comment of the defender of democracy who said, "It costs more, but it's worth it."

ISSUES COMMON TO ALL

Certain important administrative issues are common to all systems: medical administration, malingering, and adverse selection. This section will discuss the issues and the experience with them in each state.

Medical Administration

Effective medical administration is vital to a properly administered disability program. Benefits are granted only upon receipt of a certificate of disability. Since this certification constitutes the only basis upon which the fact of disability may be ascertained by the agency, its reliability, promptness, and economy are of utmost importance.

Problems. The central medical administrative function is that of certifying, or refusing to certify, a disability claimant. Whether disability should be certified by a physician engaged by the claimant or by one engaged by the agency is one problem to be settled. The qualifications of those permitted to certify, if the right of certification is not restricted to agency personnel, is another. Presumably most disabilities will be certified by physicians; nevertheless, there are other groups, such as dentists, osteopaths, optometrists, chiropodists, and chiropractors whom claimants may wish to consult. Others, because of religious beliefs, may wish to consult faith healers. Which of these groups should be granted certification privileges? If all are, how should their qualifications be defined?

Because physicians play a crucial role in the functioning of the system, it behooves the agency to enlist their wholehearted support. The purpose of the program, the use to be made of information requested, the administrative procedure followed, and the type of problems that arise should all be carefully explained to

them. The help of the medical profession should be sought in designing forms, setting fees, and developing procedures. Failure to obtain co-operation from the profession will surely lead to many formidable, even critical, problems.

The most valuable service furnished by the physician, in addition to certification of disability itself, is an estimate of the duration of the disability. Wide latitude in estimates for similar disabilities, or worse still, no estimate at all, creates problems for the agency. On the other hand, inflexible use of estimates by the agency produces problems for the attending physician. In order to verify questionable claims and certifications, or to check on disabilities of long duration, the agency may require medical re-examinations. To require these indiscriminately, or to give inadequate consideration to the attending physician's report may create discord.

The differing interests of the private practitioner and those of the industrial physician may present a problem in co-operation. The family physician is primarily interested in the welfare of his patient, and is not necessarily to be considered unscrupulous if he makes a liberal estimate of the duration of the disability. The industrial physician, on the other hand, is interested in reducing sickness absenteeism and may find himself at odds with some of the practicing physicians in his community.[42]

The relationship between the agency and the state health department may present a problem of co-operation. While very little use has been made of health department services or facilities, some believe that the skilled personnel of health department staffs could be used for review of disability certifications, control of communicable and industrial diseases, explanation of the program to employees and the public, and education in the importance of obtaining proper medical care.[43]

Experience. Much valuable experience with medical administration has been acquired by the state funds. While medical

[42] Leonard J. Goldwater, "Sickness Disability Insurance Laws in Relation to Occupational Medicine," *Industrial Medicine and Surgery*, November, 1949, pp. 473–75.

[43] Margaret C. Klem, Margaret F. McKiever, and Walter J. Lear, *Industrial Health and Medical Programs* (Federal Security Agency), pp. 361–62.

administration of group disability insurance was not new to commercial carriers, it was new to the state funds. Consequently many problems developed.

Rhode Island. Much of the early criticism of the Rhode Island program was directed toward its medical administration. The procedure in filing a claim at first required the claimant to complete a portion of the claim form himself. He then had his physician fill in a medical portion giving the diagnosis and estimate of duration of the disability. The claim was then mailed by the claimant to the agency. Upon review by the medical director, the claim was usually approved, including the estimate of duration. Weekly certification was necessary, but with the continued claim form it was permissible for the claimant himself to attest that he was disabled. Benefits were terminated at the end of the estimated duration unless the claimant submitted to a re-examination at the central office.

The medical profession had not been consulted in developing these procedures, nor were efforts made to explain the purpose of the program.[44] Consequently, their co-operation was less than enthusiastic. They resented particularly giving the claimant a copy of his diagnosis and an estimate of the duration of disability. The doctors charged that these estimates were being used as inflexible tools to discontinue benefits, with the blame being placed upon the physician as the official establishing the cutoff date.[45] The physicians reacted by failing to include prognoses. This made it difficult for the agency to determine the period for which benefits should be paid. With inadequate medical reports, it became evident that certification of continued claim forms by the claimant was subject to abuse.

The deficit experienced the first year emphasized the need for changes. Twelve physicians were employed, on a part-time salaried basis, to serve as medical examiners. Certification by claimants was eliminated. A more or less automatic scheduling for

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[44] Nathan Sinai, *Disability Compensation* (Ann Arbor: University of Michigan School of Public Health), p. 40.

[45] John E. Ferrel, "Medical Certification Under State Compulsory Disability Programs," *Industrial Medicine and Surgery*, October, 1951, pp. 464–65.

re-examination at the central agency office was required at the date set in the original prognosis. Re-examinations were conducted by the agency medical examiners. Failure to appear for an examination, unless physically incapacitated, resulted in stoppage of benefits.

This system of automatically scheduled re-examinations gave rise to unsubstantiated charges of widespread malingering. Many claimants who recovered as expected returned to work, and did not appear for re-examination. When they failed to appear as scheduled, it was incorrectly deduced that they had been malingering and failed to appear because they feared discovery of their ruse. The agency was criticized also for scheduling unnecessary examinations and causing patients hardship in requiring examinations. The agency countered that many of the apparent shortcomings were attributable to lack of co-operation by the medical profession.[46] This alleged lack of co-operation prompted further changes.

Several administrative alterations were made. The physician was no longer required to give his report to the claimant, but to send it directly to the agency. This eliminated a frequent source of conflict. With few exceptions, the agency now receives an estimate of duration of the disability from the physician, the one most qualified to do so. Since considerable reliance can be placed upon this estimate, the new procedure has been a progressive step.

Agency part-time medical examiners have been eliminated. In their stead, use is made of practicing physicians for independent medical examinations of selected cases on a fee basis. This change was prompted, in part, by the medical profession's antagonism to governmental medicine. The profession greatly prefers the present system. In most cases the attending physician's initial estimate is used. Weekly certification is eliminated. Shortly before expiration of the original estimate, the physician is again requested to estimate the duration. If a marked disparity exists between this estimate and that made by the medical director of the agency, and in other questionable cases, an independent medi-

[46] Rhode Island Unemployment Compensation Board, *9th Annual Report* (1944), pp. 22–23.

cal examination is ordered. This is performed by a physician, other than the claimant's doctor, chosen from a panel of physicians in the appropriate areas. Every member of the Rhode Island Medical Society is eligible to register for these panels either as a general practitioner or as a specialist. The list is drawn from in rotation. The agency now employs a full-time medical director and two physicians on a part-time basis. Their primary responsibility is to review claim forms.

While procedural changes were an important factor, probably of greater significance in explaining the improved administration of the Rhode Island system are the improved relationships between the agency and the medical profession. Agency personnel has visited all the local medical societies in a concerted effort to acquaint physicians with the program and its problems. The advice of the State Medical Society was sought in reorganizing procedures. A medical committee has been appointed to advise the agency. Medical opinion is sought when pertinent changes are considered. And when changes are made, members of the profession are promptly informed of all details. Relationships between the two groups have steadily improved since 1949, with mutually beneficial results.[47]

A recent outgrowth of this co-operation has been the development of a table of average durations of disability, valuable as a guide to physicians and to the agency.[48] This project was carried out by the medical profession.

Prior to 1951 only licensed medical doctors were qualified to certify disability claims. Now any one "licensed to practice medicine, surgery, dentistry, chiropractic, osteopathy, and chiropody" may certify claims.[49]

California. Medical administrative problems have been few in California. The advice and assistance of the medical profession

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[47] From personal interviews. See also, Nathan Sinai, *An Analysis of Rhode Island Cash Sickness Compensation* (Ann Arbor: University of Michigan School of Public Health, 1950).

[48] Similar tables are used in California and New Jersey. They are particularly useful when lay claim examiners are used.

[49] Rhode Island Temporary Disability Insurance Rules and Regulations, Regulation I, 1a.

were sought early. The program has also been aided by the exceedingly fortunate selection of a capable medical director. He has been a good administrator, and, more important, has obtained excellent co-operation from the profession.

The medical director is not in the Division of Disability and Hospital Benefits, but is directly responsible to the director of the Department of Employment. The director has headquarters in the central office in Sacramento, and assistant medical directors are located in San Francisco and Los Angeles. Much of the claim-review work is done by lay examiners, trained by the medical director. The procedure followed is that after which the Rhode Island program, described above, is patterned. There is greater decentralization in California, however, due to the size of the state. Claim certification is permitted by physicians, surgeons, chiropractors, osteopaths, dentists, chiropodists, and also by religious practitioners authorized on the basis of application from their churches. Few problems have arisen from this liberal certification procedure.

New Jersey. New Jersey's organization is unique. All medical services are supplied by the State Health Department. Advantages of this arrangement, particularly important in the early days, are that a trained staff is organized, important relationships with the medical profession have been established, and varied statistical services are available. One big disadvantage may be that the disability insurance program is not the first interest of the men assigned to it. Another disadvantage is that the agency has no administrative authority over the medical representatives. For this reason it has not been possible to have them represent the agency in its contacts with the medical profession.

The agency believes that a medical staff of its own would be more satisfactory. Such an arrangement would make the staff available when desired, and would enable it to participate with the agency in policy decisions. The experience has been that Health Department personnel have only a secondary interest in the disability program.

The absence of a full-time medical director increases the responsibilities of the lay claims examiners. Claim procedure is

similar to that now used in California and Rhode Island, but there are differences in the use of independent medical examiners. Although permitted, no procedures were developed during the first year of the program for independent examinations. During 1950 a procedure was developed, with the co-operation of the state medical society, whereby an independent examination was arranged by the claimant's personal physician.

During the next two years only three hundred independent examinations were requested by the agency. This was less than 0.5 per cent of claims filed, which was less than one tenth of the percentage of such examinations in California.[50] Of the claimants scheduled for these examinations, more than one-fourth failed to report for the examination. This was approximately five times as many as failed to report in California. Less than 20 per cent of the examinations conducted resulted in termination of benefits, whereas the percentage of such cases denied benefits in California was about 40 per cent.

The fact that no procedures for independent examinations were developed the first year, and relatively few examinations were conducted during the following years, was attributed to the lack of a full-time medical director. The larger proportion of claimants failing to report for examinations suggests that malingering was fostered by the lax medical administration. The low percentage of denials in the cases examined was attributable, in part, to the natural reluctance of a consulting physician to give an opinion differing from a colleague.

The shortcomings discussed above necessitated changes in the procedure followed for independent examinations. Since 1952 the county medical societies have designated independent examiners. Improvements have resulted; nevertheless, use of this procedure is relatively infrequent. This is deemed a consequence of lax supervision by the Health Department.

New York. No medical administration problems of consequence have been reported in New York. Most claims are filed

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[50] From personal interviews with administrators of the New Jersey Disability Insurance Service; also, U.S. Department of Labor, *California Disability Insurance Program* (1952), p. 13.

with private carriers in accordance with their usual group disability insurance procedures. Claims filed with the Special Fund follow the procedure established for workmen's compensation. This procedure, established over a period of years, had been made relatively trouble free by the time the disability program was added.

Commercial Carriers. Most commercial carriers use the same claim-certification procedure for temporary disability claims as that developed for group accident and sickness insurance. These procedures vary with different companies. Usually, in conjunction with a statement by the claimant, a report is required from the attending physician giving the diagnosis and probable duration of the disability. Claims are reviewed in the home office and payment is made if all is in order. As a rule, continued certification within the estimated period of duration is not required. Disabilities persisting beyond the estimated duration are reviewed. If malingering is suspected a private investigator checks with the certifying doctor or checks the activities of the claimant. Only occasionally do carriers make use of the policy provision permitting them to examine the claimant.[51]

With large groups the policyholder (this includes unions and trustees of welfare funds, as well as employers) is frequently permitted to administer claims, subject to supervision by the insurance carrier. He is given an insurance-company draft book from which claims are paid. These cases may be written on a "retention" basis, i.e., premiums charged consist of claim costs plus a small additional percentage, or net cost may be determined by individual claim experience through use of dividends. The policyholder's financial interest presumably assures adequate claim administration. Occasionally employers request an investigation of a potential malingerer by the carrier. While medical administration of these self-administered cases varies widely, the industrial infirmary and visiting-nurse program are frequently utilized.

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[51] Edward A. Green, "Underwriting, Reinsurance and Claim Adjustment-Group Contracts," *Accident and Sickness Insurance*, David McCahan (ed.) (Philadelphia: University of Pennsylvania Press, 1954), pp. 180–81.

Summary

Medical administration is very important in temporary disability insurance. A co-operative medical profession is essential. It behooves the disability agency to seek the advice of this group when first developing medical administrative procedures. Moreover, a constant liaison with the profession should be maintained.

A medical doctor should be employed as a full-time medical director. Lay claims examiners can be used effectively, however, with proper training and supervision. The disability agency should not employ examining physicians. Closer co-operation with the profession can be achieved by using independent medical examinations conducted for a fee. Experience indicates that claim certification can be permitted by any qualified person treating disabled claimants.

MALINGERING

Malingering—the practice of feigning disability—in order to collect benefits is not a problem unique to state compulsory disability insurance. This is a besetting problem to voluntary accident and sickness plans as well. Compulsory health insurance programs in Europe have also had to cope with this problem.[52]

Problems

Since disability itself is difficult to identify, the detection of malingering is always difficult, often impossible. A complicating aspect is that a borderline case often shades into malingering. Physicians often hesitate to certify as ready for work one who shows no evidence of organic disorder but who "doesn't feel well."

Prevention of malingering depends primarily on effective medical administration. Improper certification by physicians can lead to widespread abuse. The primary problem with malingering, some contend, does not arise from those submitting completely

[52] Walter Sulzback, *German Experience with Social Insurance* (National Industrial Conference Board, 1947), chap. 3.

unjustified first claims, but rather from those who attempt to prolong receipt of benefits longer than warranted. From this group there is often considerable pressure upon the personal physician to authorize claims against his better judgment. The physician who does not co-operate in such malingering may lose a portion of his practice to a competitor whose concept of disability is more liberal.

The period required for convalescence is often influenced by such factors as the net difference between income received while disabled and that received while on the job, the number of suitable jobs available, and the responsibilities of the claimant at home and on the job. Potential malingerers increase as benefits become a higher proportion of earnings. When job opportunities are scarce, there is a tendency to prolong receipt of benefits. Secondary wage earners, such as the housewife who works to pay for a new refrigerator, often have questionable disabilities. Relatively few cases of malingering are attributable to foremen, supervisors, and others with responsible positions.

Disability insurance claimants are also exposed, to a greater or lesser degree, to the temptation of getting "something for nothing." To the extent that this philosophy influences claimants, malingering can be expected to increase. Some claimants conceive of disability insurance as a banking arrangement; since they contribute, they must receive at least an equal amount in benefits. Such thinking contributes to malingering.

Losses from malingering are more extensive than the increased benefit costs. Absenteeism, whatever the cause, is expensive to employers. Costs of lost production, as well as of hiring and training of substitutes, constitute some of these expenses. Disability benefits must often be supplemented by welfare grants. Thus, malingering may mean increased welfare expenditures. In addition, malingering weakens the moral fiber of the deceitful claimant. The whole community loses as a consequence.

Control

An important control of malingering is the medical certificate required with each first claim. Additional medical certification

may be prescribed for continued claims. Where the certifying physician's prognosis is questioned, or where collusion is suspected, the agency may insist upon re-examination of the claimant by a physician designated by the agency.[53]

It is claimed that malingering is more prevalent in plans permitting free choice of doctor.[54] Consequently agency doctors have been proposed. Such propositions are actively opposed by the medical profession. Moreover, Rhode Island's experience with agency doctors suggests that careful consideration needs to be given such proposals prior to adoption.

Another device that can be utilized by the agency, is to have field investigators make unscheduled visits to the claimant's home. The investigators may deliver a benefit check in order to establish rapport. The purpose of these visits is to see whether the claimant's appearance and activities correspond with the statements as to his physical condition. The representative may also question the claimant on other aspects of eligibility, such as his status in the labor market. Such visits are less expensive than medical re-examinations. While the two methods of verification do not serve entirely the same purposes, they supplement each other.

Since employers lose from malingering, even when they do not contribute to the insurance plan, it is to their economic interest to aid in its control. Control is best accomplished by training the supervisory staff. It is believed that foremen, and other direct supervisors, are in the best position to know when a man is able to work.[55]

Labor, too, has an interest in controlling the problem of malingering especially in those plans underwritten by the union. Workers can suffer in diverse ways from abuse of a program designed for their benefit. Malingering has not been a major problem under union plans because constant vigilance is exercised by

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[53] See *Medical Administration* above.

[54] National Industrial Conference Board, *Compulsory Sickness Compensation for New York State* (1947), p. 171.

[55] Elinore M. Herrick, "The Problem of Malingering Under State and Voluntary Plans," *Conference Board Management Record*, June, 1949, p. 264.

local shop union committees.[56] Educational programs initiated by the union can be of real significance in controlling the problem.

Experience

None of the programs have been subject to widespread abuse by malingerers, although there were reports to the contrary with reference to Rhode Island's experience. The fixed benefit year, beginning in April, resulted in a peak claim load during the spring. Since this season normally has a small number of claims, this abnormality was thought to be evidence of excessive malingering.[57] An understanding of the statute would have obviated such a conclusion. The elimination of the fixed benefit year[58] was followed by a more normal claims experience during the months of April and May.[59]

Additional charges of malingering in Rhode Island were based upon the fact that a large proportion of claimants called in for medical re-examination by the agency failed to appear.[60] This was interpreted to mean that many had been receiving benefits without justification and feared examination. A partial explanation of this was that the agency automatically scheduled claimants for examination at the expiration of the period of original prognosis, and consequently, when a large proportion failed to appear it merely indicated that many claimants had recovered as anticipated. Reorganization of medical procedures in 1949, eliminating automatic re-examinations, also removed much of the basis for these charges.[61]

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[56] Adolph Held, "Health and Welfare Funds in the Needle Trades," reprinted from *Industrial and Labor Relations Review*, January, 1948, pp. 14–15.

[57] See Chapter 8, "Benefit Year."

[58] The benefit year, the period during which certain benefits rights could be exercised, now begins with the inception of disability, rather than in April.

[59] Rhode Island Department of Employment Security, *17th Annual Report* (1952), pp. 26, 59, 60.

[60] New York Department of Labor, *Studies in Disability Insurance* (1949), p. 100.

[61] Approximately 20 per cent of claimants failed to appear for the automatically scheduled medical examinations. This figure dropped approximately 50 per cent when the system was changed to one of selective examinations.

Other reasons given for claimants failing to report for examinations are that some had left the labor force, and some, though disabled, refused to be examined by a physician in a public agency.

Studies in Rhode Island have shown that approximately 40 per cent of claimants examined by independent medical examiners were certified as able to return to work. A limited study in California indicated that 55 per cent of claimants subjected to such an examination were denied further benefits. This same study reported that 12 per cent of claimants scheduled for these re-examinations failed to appear.[62] The extent of malingering in such cases is difficult to determine. It is probable, however, that a good proportion could have returned to work prior to the scheduled examination.

Rhode Island, California, and New Jersey use field investigators to gain additional information and to spot-check claims. Investigators are utilized similarly by commercial carriers in those states permitting private plans. Few instances of malingering have been noted by either group. Provisions for independent medical examinations are made in all states.

Summary

Malingering is a potential problem with all disability insurance. Nevertheless, most people who have worked with state disability programs agree that malingering has been overemphasized by critics of compulsory plans. Proper administrative safeguards, active co-operation by the medical profession, and education of employees should serve as adequate controls.

ADVERSE SELECTION

When private plans are permitted to compete with a state fund, the problem of adverse selection arises. Adverse selection in temporary disability insurance results when private plans insure the better risks on the average, and the state fund is left with the less desirable risks. This process tends to increase benefit costs of the state fund.

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[62] Marvin S. Averbook, "The Malingery Problem in Disability Insurance," *Review of Insurance Studies*, Vol. II, No. 2 (1955), p. 75.

The Problem

Adverse selection is a more serious problem when a uniform contribution rate is charged. Where such a rate is in effect and contracting out is permitted, groups with better-than-average disability experience benefit from contracting out. Equal benefits for lower cost or increased benefits for the same cost are possible. It is to the advantage of groups with experience worse than average to remain with the state fund. If the original contribution rate has been based upon average experience, it will not be adequate for the group covered by the state fund. This could lead to financial insolvency. Raising the contribution rate would only aggravate the selection process.

The fact that adverse selection can occur under contracting out is not questioned. There is question, however, as to whether or not such a process is inevitable, and whether or not statutory or administrative procedures are necessary to safeguard against it.

Arguments for Safeguards

The primary basis for the argument that safeguards are necessary to prevent selection is that insurance companies are business enterprises, and as such must cultivate business that is profitable —at least in the long run. Insurance company administrative costs are somewhat higher than those of state funds.[63] Therefore, if the statutory rate is merely adequate for the state fund, commercial carriers cannot profitably insure groups representing the average disability risk, let alone those in which the risk is poorer than average. Consequently, commercial carriers have to select groups which, on the whole, are better than average or they will lose money. The alternative is to set a more adequate rate for the state fund. This, however, would be only a temporary expedient. An excessive rate would create surpluses in the state fund which could in turn give rise to demand for benefit increases. That

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[63] See section on "Administrative Costs" above.

would leave the insurance companies in the above described predicament.[64]

Arguments against Safeguards

Advocates of private plans deny that adverse selection is inevitable with a competitive state fund. A number of considerations, other than cost, affect the decision as to whether a group will contract out or remain with a state fund. An employer with an established comprehensive insurance program will often prefer to incorporate statutory disability benefits within his program, even at an increased cost, for reasons given below. Usually, however, statutory disability benefits can be added to a comprehensive program for a relatively small additional cost since administrative costs are shared with the other benefits. A plan may be provided because the employer wishes to provide more liberal benefits, because he wants to be associated with benefits in the eyes of his employees, or because he desires to take a more active part in administration than the state plan would allow. A union may prefer a private plan for the same reasons.

Insurance companies have been criticized for restricting their writing to large groups in order to keep expenses low. While this has been usually true in the past, evidence is not conclusive that it has resulted in selection against the state plan. State plans, with compulsory coverage resulting in low acquisition costs, have experienced low expense ratios for the small groups, and in addition have benefited by the low loss ratios characteristic of the small groups.[65]

It is possible for such administrative safeguards to restrict the right of employers to select the private plan desired. For example, in California, where the percentage of women in all groups written by each carrier was the criterion of selection used, a particular employer applied for a plan with an insurance company. Since the addition of this plan would have reduced the carrier's female

[64] U.S. Bureau of Employment Security, *Temporary Disability Insurance—Problems in Formulating a Program Administered by a State Employment Security Agency* (1953), p. 10.

[65] See "Financial Experience of Private Plans," Chapter 9.

percentage below the minimum permitted, the plan was denied. The carrier later raised its percentage of women and was permitted to write the plan, but the problem is a real one.[66]

Experience

There has been more discussion of the problem of selection with reference to California's experience than with either New Jersey or New York, probably for several reasons. First, the California law was the earliest to permit private plans; second, California statutes and administrative rulings highlighted the subject; and thirdly, the detailed reports required in California have made more information on the subject available.

California. The statute merely provides that a private plan may be approved if "the approval of the plan or plans will not result in a substantial selection of risks adverse to the Disability Fund."[67] By administrative ruling, the measuring rod applied under this regulation was the percentage of women covered under the total number of plans written by each insurance carrier in effect at a particular date. In 1946 it was estimated that women composed between 25 and 30 per cent[68] of the labor force in California, so the criterion of a minimum of 20 per cent female coverage for each plan was chosen. It was realized that many factors other than the proportion of women influence the disability rate of a group, but this criterion was chosen since it was a major factor and was thought to lead to easy administration. It is reported that the 20 per cent proportion was suggested by the industry.

For each insurance carrier a cumulative record has been kept of the percentage of women in all its plans. All self-insurers are considered as a single group. Approval of a plan which will reduce a carrier's over-all percentage of women to less than 20 per

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[66] This rule provides that in the event the carrier's female percentage for all plans should fall below the minimum, it has six months to raise this percentage. If the minimum is not met within this period, the agency may withdraw approval of all plans insured by the carrier.

[67] California Unemployment Insurance Code, Section 3254(h) (1953).

[68] The 1950 Census determined this proportion to be approximately 30 per cent.

cent is denied. If a carrier's female percentage falls below 20 per cent, it has six months to raise it to the required minimum. No plan or plans submitted during that six months are approved unless they can bring the over-all percentage to 20 or more. If the 20 per cent requirement is not met within this period, the agency can withdraw approval of all plans insured by the carrier. This has never occurred, however, since no carrier has failed to meet the minimum requirements.

Industry representatives did not anticipate difficulty in meeting the 20 per cent regulation, but some learned otherwise. Department stores, and other large employers of women, were granted favorable contracts in some cases by carriers anxious to raise their female percentage. Since some companies were experiencing difficulty in meeting the 20 per cent limit, the industry pressed for changes.[69] The plea was supported by figures showing the surplus accumulated by the state fund and the low profit margins experienced by most carriers. During the 1953 legislative session a bill was passed declaring a two-year moratorium on the adverse selection rule, effective January 1, 1954. In 1955 the moratorium was extended an additional two years. It is the understanding of the industry that the agency continued to keep account of the female percentage in private plans during this moratorium. Consequently, the companies have endeavored to maintain as high a proportion of women in their plans as is feasible.

New Jersey. Since the New Jersey State Fund applies experience rating, adverse selection has not been the problem it is in California.[70] This will continue to be true, however, only if the Fund's rate structure is sufficiently responsive. In the original law there were restrictions on the applicability of experience-rating

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[69] The average female percentage of all voluntary plans was never in danger of going below the requirements. In June, 1951, this percentage was 24.4 per cent—two years later it was 22.8 per cent.

[70] While it is possible for the state fund to insure more than a proportionate share of the poor risks, the experience rating enables the fund to charge such risks a premium higher than the average. Consequently no grossly adverse financial experience results from the selection.

To be sure, the poorer risks may be charged a higher insurance rate and still produce results relatively less favorable than better risks at lower rates, but such selection has apparently not been subject to controversy.

provisions; only those groups credited with at least $1,500 of contributions, and at least two years of experience were eligible for experience rating. This meant that only the larger groups could qualify.

Together with this limitation was a second minor restriction on adverse selection. The statute also permitted private plans to "exclude a class or classes of employees; provided, it does not appear to the division that such exclusion will result in a substantial selection of risk adverse to the State Plan."[71] The rule was often interpreted to mean that an employer could not insure his male production employees under a private plan and leave his female stenographers with the State Fund.

Curiously enough, this latter provision was more troublesome to labor groups than to the insurance industry. In New Jersey many private plans are negotiated by unions.[72] In many instances unions would negotiate with employers and arrange to cover their members under the union plan. For example, a truck drivers' union would negotiate with many trucking firms. In many instances this meant the employer's remaining employees, a stenographer or two, would be left to be covered by the State Fund. Since this was interpreted to result in selection against the Fund, it was not permitted. Consequently, changes were urged.

The 1953 legislature passed two companion bills. One modified the adverse selection rule; the other made experience rating applicable to all groups, regardless of size. It is now possible for an employer to include all but a few female employees under a private plan, since the remaining employees can be insured with the State Fund without raising the question of selection. But if the experience of the group left with the State Fund is poor, the employer will pay a higher contribution rate to the Fund.

There never has been a provision prohibiting insurance companies from writing all the employees of one employer, even though it may be evident that some adverse selection is exercised.

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[71] New Jersey Temporary Disability Benefits Law, Section 43:21–32(f) (1952).

[72] Some union-negotiated plans are self-insured while others are insured with commercial carriers.

Evidence that selection has taken place is that 42 per cent of workers covered by the State Fund are women, whereas, women constitute but 25 per cent of workers covered by private plans. The State Fund covers 33 per cent of all eligible workers. Yet in the "contract construction" and "farming and fisheries" industries, both having many small groups, which are relatively more costly to administer, the Fund covers 59 and 74 per cent, respectively, of all eligible workers.[73]

New York. In New York the State Insurance Fund, as well as insurance companies, charges premium rates, manual and individual risk, appropriate to the particular risks insured. Consequently, adverse selection has not been a major issue. Critics of the program feared that the Fund would have to insure most of the poor risks, despite the rating provisions. Experience has proved these fears to be groundless. Loss ratios were as low as 32 per cent in 1951 and 48.7 per cent in 1954.[74] Furthermore, the Fund reportedly has had the lowest net premiums.

Conclusions

If a uniform contribution rate is used in conjunction with a state fund, the fund should be protected against adverse selection. It probably will be necessary to have statutory provisions, e.g., a debit and credit system based on several factors relevant to selection such as age, sex distribution, and wage patterns of the group, to assure this protection. Ease of administration should be an important consideration in devising such a provision.

In the interest of good public relations, it would seem prudent for insurance companies to co-operate wholeheartedly in protecting the state fund against selection. If handicaps are not imposed on them, insurance companies can compete very effectively with a state fund. Efficient administration, faster claim service, and plans adaptable to the particular needs of the group should enable the companies to write profitably a cross section of the risks.

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[73] New Jersey Division of Employment Security, *17th Annual Report* (1953), Tables 19 and 20.

[74] These ratios are incurred losses and loss expenses to earned premiums before dividends. From reports of the New York State Insurance Fund.

THE FEDERAL-STATE ISSUE

There remains the possibility of passage of a nationwide system of temporary disability insurance at the federal level. There has been less discussion of this since the inauguration of a Republican administration; nevertheless, the subject merits consideration.

Arguments for Federal Action

Most of the support for federal action has come from national labor organizations and the Federal Security Agency. Persuasive reasons support their arguments. One of the most cogent of these is that workers throughout the nation are confronted with losses due to temporary disability, and only through federal legislation can universal coverage be achieved and an adequate minimum of protection be provided for all workers.[75] Disability insurance developed at the state level will result in a disparate patchwork of coverage, benefits, financing, and administration. A duplication of workmen's compensation experience is to be avoided, it is said. It was almost thirty-five years before every state passed workmen's compensation laws, and even today the extent of the coverage and protection afforded leaves much to be desired.[76] State legislation will lead to unjustified cost differences among competing firms if some states pass disability laws and others do not. State systems may produce artificial restrictions on labor's mobility, which are not suitable in this country where many workers move from state to state.

It is pointed out by these same advocates that temporary disability insurance has been made a successful part of a national social insurance program in most industrialized countries. They

[75] David Kaplan, "Attitude of Organized Labor Toward Sickness Disability Insurance," *Archives of Industrial Hygiene and Occupational Medicine*, December, 1950, p. 671.

[76] Harry Becker, "Recent Developments in Employee Disability Programs," *Journal of the American Association of University Teachers of Insurance*, March, 1950, p. 45.

believe that our present old-age and survivors insurance program could be geared to the administration of disability insurance. Administrative costs would be reduced thereby to a minimum.[77] These groups which demand, as well, a national permanent disability insurance program, show the desirability of dovetailing temporary and permanent disability insurance.

Arguments against Federal Action

Those favoring action at the state level counter with persuasive arguments. As might be expected, the most vocal opponents of federal legislation have been representatives of employer groups, the insurance industry, and state governments. One of the most telling arguments in favor of state legislation is that even though temporary disability is nationwide in occurrence, the consequences are a local problem and can be handled better at the state level. Uniformity of provisions is not necessarily desirable. The needs of industrial and agricultural communities are different. It is probable, for example, that a scale of benefits suitable for New York may be inappropriate for Mississippi. Temporary disability insurance, unlike old age and survivors insurance, requires considerable discretion in its administration; discretion in determining the extent of disability and in preventing malingering.

If disability insurance dealt with the causes of disability and were designed to eradicate them, then perhaps it would be planned and executed better on a nationwide basis. But that is not the case. It is a mitigating measure, not a cure. The aim of disability insurance is not to abolish disability, but to aid its victims. As a mitigating measure it can serve better if it is localized, personal and direct.[78]

Since compulsory disability insurance is new in this country, state legislation permits desirable experimentation. There have been many developments and changes since Rhode Island passed the first law. California, New Jersey, and New York have profited

[77] Wilbur J. Cohen, "Recommendations to Improve the Old-Age and Survivors Insurance Provisions of the Social Security Act," *New York University Second Annual Conference on Labor*, p. 308.

[78] Herman Gray, *Should State Unemployment Be Federalized?* (New York: American Enterprise Association, 1946), p. 58.

measurably from Rhode Island's experience. Many believe it would have been disastrous to have enacted the early Rhode Island law at the federal level.[79]

Federal legislation would probably bar commercial carriers. This could lead to the widespread cancellation of voluntary plans. Consequently many workers currently covered by generous voluntary plans might suffer a loss in benefits.

Many view with alarm the tendency of the federal government to play an increasingly important role in controlling the welfare of its citizens. It is said that too much security will stifle the initiative which has made the United States of America great. Another trend of the federal government is to provide services which have been supplied traditionally by private enterprise. Disability insurance is cited as a field in which private enterprise has done, and can continue to do, a satisfactory job without the need for the federal government to intrude.

Federal Enabling Legislation

It has been proposed that in lieu of a program federally administered, legislation could be enacted that would encourage suitable action in the several states, as was the case with unemployment insurance. Congress, through a new title to the Social Security Act, could establish minimum standards for coverage, benefits, finances, and administration. As in unemployment insurance, credits could be allowed against a federal payroll tax for a state insurance program that would meet minimum federal standards. A uniform system could thus be assured in a minimum of time. At the same time sufficient flexibility could be allowed for states to make provision for varying risk and cost factors. Opportunities for more than minimum benefits likewise would be provided. This program would permit administrative operation by the states, affording the localized, personal attention deemed necessary for disability insurance.

This approach has its own critics. Mindful of unemployment

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[79] Morton D. Miller, "Probable Future Developments in Sickness Disability Insurance," *Archives of Industrial Hygiene and Occupational Medicine*, December, 1950, p. 659.

insurance experience, many state legislators and administrators would be reluctant to have a similar system established for disability insurance. Federal supervision, exercised primarily through control of administrative grants of the unemployment insurance program has been a source of much contention, although as time goes on this has become less acrimonious. It has been said that control of the purse strings is tantamount to complete control. Control at the local level under such a system would be more fiction than fact, many believe. This system, too, might exclude private insurance and would promote what many fear is a trend toward statism.

Trends

Opinion is divided as to probable federal temporary disability legislation. Some believe that if compulsory systems are passed in twelve or fifteen states the patchwork of heterogeneous provisions resulting could lead to a federal system of some kind.[80] Passage of a federal permanent disability insurance program, proposed on several occasions, will probably be accompanied by strong pressures for companion legislation providing insurance for temporary disability. Others are of the opinion that the existence of state programs will eliminate the pressure for a federal plan. As more states enact such legislation and existing programs are perfected, the probability of federal action becomes more remote.

It is unlikely that any concerted effort will be made for disability insurance legislation at the federal level within the foreseeable future. The present political climate is such that states' rights dominate. In the event that there is a swing back to the liberal policies of the New Deal, federal temporary disability insurance will surely be given serious consideration.

[80] E. H. O'Connor, *National Underwriter*, February 21, 1952, p. 32.

Appendixes

APPENDIX • A

Application for Rhode Island Disability Insurance

(Filled out by Worker)

TDI-1 (9/53) **APPLICATION FOR RHODE ISLAND TEMPORARY DISABILITY INSURANCE**

FOLD ON THIS LINE FOLD ON THIS LINE

1. PRINT NAME AND ADDRESS (IF MARRIED, INCLUDE MAIDEN NAME)

FIRST (INITIAL OR MAIDEN) LAST

3. MAILING ADDRESS: NO. STREET, OR R.F.D. CITY STATE

HOME ADDRESS: NO. STREET CITY STATE

4. PHYSICIAN'S NAME (IF CLINIC PATIENT, NAME HOSPITAL)

NO. STREET CITY STATE

5. WERE YOU INJURED WHILE WORKING? YES ☐ NO ☐

6. DATE LAST WORKED

7. FIRST DATE OF UNEMPLOYMENT CAUSED BY YOUR DISABILITY

8. DATE YOU LAST RECEIVED EMPLOYMENT SECURITY BENEFITS

9. CHECK THE DAYS OF THE WEEK YOU NORMALLY WORK. SUN. ☐ MON. ☐ TUES. ☐ WED. ☐ THUR. ☐ FRI. ☐ SAT. ☐

2. YOUR SOCIAL SECURITY NUMBER

___ ___ ___ | ___ ___ | ___ ___ ___ ___

10. AGE

11. MALE ☐ FEMALE ☐

12. MARRIED ☐ SINGLE ☐

13. ARE YOU PREGNANT? YES ☐ NO ☐

14. OCCUPATION

15. REASON FOR LEAVING WORK

16. DATE FIRST TREATED OR EXAMINED

17. DATE OF YOUR LAST EXAMINATION

18.

A. NAME OF FIRM.....

ADDRESS.....

BEGINNING DATE ..... MO. DAY YR.

ENDING DATE ..... MO. DAY YR.

C. NAME OF FIRM.....

ADDRESS.....

BEGINNING DATE ..... MO. DAY YR.

ENDING DATE ..... MO. DAY YR.

B. NAME OF FIRM.....

ADDRESS.....

BEGINNING DATE ..... MO. DAY YR.

ENDING DATE ..... MO. DAY YR.

D. NAME OF FIRM.....

ADDRESS.....

BEGINNING DATE ..... MO. DAY YR.

ENDING DATE ..... MO. DAY YR.

19. I HEREBY CERTIFY that I am physically unable to perform my regular or customary work and further that I am not self-employed. I also certify that the statements made by me on this application are true and correct to the best of my knowledge and belief and I authorize my physician to disclose all necessary information.

SIGNATURE OF WITNESS, IF WORKER SIGNS (X) ..... DATE ..... SIGNATURE OF WORKER OR AUTHORIZED AGENT .....

FOLD UP SO THIS EDGE WILL MEET LINE AT GUMMED FLAP

Statement by Attending Physician

THOMAS H. BRIDE
Director

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
DEPARTMENT OF EMPLOYMENT SECURITY
P. O. BOX 1927 PROVIDENCE 1, RHODE ISLAND

Division of
Temporary Disability Insurance

TDI-3 (9/53)

STATEMENT BY ATTENDING PHYSICIAN

(Please Return This Form Immediately in Order that Payment of Benefits Will Not Be Delayed.)

1. Soc. Sec. Number

ATTENDING PHYSICIAN

2. Name of Patient

3. Address City

Date_____

Age_____

4. State nature and cause of incapacitation and attendant complications.

_____

_____

_____

_____

5. Operation (type)_____

10. Enter here_____ the date you first examined patient for present sickness subsequent to this date_____

11. Enter date of most recent examination_____

12. Specify if patient is pregnant Yes ☐ No ☐

13. Specify if miscarriage Yes ☐ No ☐

If Yes, enter date of completion_____

14. If injury, enter date_____

15. Is patient mentally and physically capable of

signing checks and documents Yes ☐ No ☐

6. Operation Performed To be performed

Enter Date _____ _____

7. Patient treated at: Home ☐ Hospital ☐ Office ☐

8. Name of Hospital _____

9. Is Patient able to work pending operation Yes ☐ No ☐

16. Check tests performed and enter findings below:

A. Blood Count ☐ E. Urinalysis ☐

B. Blood Chemistry ☐ F. X-Rays ☐

C. Basal Metabolism ☐ G. Other (describe)

D. Electrocardiograph ☐ _____

_____

IMPORTANT — It is necessary that you estimate the number of days or weeks you believe this patient will be incapacitated to the extent that he will be unable to perform his regular or customary work. Answers such as "Indefinite" or "Unknown" will not suffice. Even if considerable question exists at this time, an estimate must be made. The estimate may be changed at a later date if the patient's condition warrants such action.

17. Your estimate to begin from _____ Enter estimate → _____ DAYS _____ WEEKS

I HEREBY CERTIFY that I examined the above-named patient on the date indicated in Item 10 and that he is incapacitated and as a result thereof, he will be unable to perform his regular or customary work at least for the period indicated in Item 17.

_____ DATE _____ SIGNATURE _____ DEGREE

FOLD UP SO THIS EDGE WILL MEET LINE AT GUMMED FLAP

APPENDIX • C

Employee Wage and Termination Report

(Filled out by Employer)

TDI-4

STATE OF RHODE ISLAND
DEPARTMENT OF EMPLOYMENT SECURITY
Temporary Disability Insurance
Employee Wage and Termination Report

S. S. No. DATE_____

NAME

EMPLOYER NAME AND ADDRESS

QUARTER ENDING DATES	WAGES
1 _____ 195	$_____
2 _____ 195	$_____
3 _____ 195	$_____
4 _____ 195	$_____
TOTAL:	$_____

The person named has filed a claim for Temporary Disability Insurance. You are required to report on this form wages which are reportable to the Rhode Island Department of Employment Security. Do not include any wages for employment which are reportable to another state. A report of wages by calendar quarter must be inserted above if total wages were "Under $3000." Complete this form and mail it not later than

_____

ITEM 1 — Enter date this person last worked for you:

ITEM 3 — Explain any reason that might lead to disqualification from benefits

---

ITEM 2 — Check reason for unemployment:

Laid off for lack of work	☐	Labor dispute	☐
Discharged for misconduct	☐	Not qualified	☐
Voluntary quit	☐	Vacation	☐
Sickness	☐	Pregnancy	☐

ITEM 4 — During the four completed quarters beginning _____ and ending _____ this worker was paid _____.

(Insert either "Over $3,000" or "Under $3,000")

ITEM 5 — If answer to item 4 is "Under $3,000," enter the ending dates of each of the quarters this individual worked for you, the wages paid in each quarter, and totals. **BE SURE TO ENTER QUARTER ENDING DATES.**

ITEM 6 — Explain if wages were reported under a different name or Social Security Number or if worker were a student or pensioner:

ITEM 7 — If worker's name does not appear on your payroll for the period in question, check: Not Employed ☐

ITEM 8 — If there were no wages subject to the Rhode Island Employment Security Act, check: None ☐

I DECLARE AND CERTIFY that this wage and termination report has been examined by me and to the best of my knowledge and belief is a true, correct, and complete report made pursuant to the Employment Security Act and the regulations issued under the authority thereof.

Signed _____ Title _____ DATE _____

FOLD THIS FLAP OVER TOP EDGE OF FORM, MOISTEN AND SEAL. DO NOT STAPLE.

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This book has been set in 12 and 10 point Intertype Garamond leaded 1 point. Chapter numbers are in 14 point Deepdene italic caps and chapter titles in 18 point Deepdene italic caps and lower case. The size of the type page is 24 by 42 picas.

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